COIMISIÚN FIOSRÚCHÁIN
UM EASLÁINTE MEABHRACH

TUARASCÁIL
1966
REPORT

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COMMISSION OF INQUIRY
ON MENTAL ILLNESS

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1966

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REPORT OF THE COMMISSION OF INQUIRY ON MENTAL ILLNESS

SUMMARY

(A) GENERAL

The Commission's review of the health services for the mentally ill has resulted in this unanimous Report.

Mental illness constitutes one of the major health problems of modern society. It has been estimated in other countries that, at present, about one of every three people seeking medical treatment at general practitioner level has a psychiatric aspect to his illness and that about one person in twelve, at some stage of life, is likely to need in-patient psychiatric care. In many countries, 30 per cent to 40 per cent of the hospital beds are assigned to the mentally ill.

In Ireland, approximately 7.3 psychiatric beds were provided in 1961 per 1,000 of the population; this rate appears to be the highest in the world and compared with 4.5 in Northern Ireland, 4.6 in England and Wales, 4.3 in Scotland, 2.1 in France and 4.3 in U.S.A. At any given time, about one in every seventy of our people above. the age of 24 years is in a mental hospital. When it is remembered that every mentally ill person brings stress into the lives of people around him, it will be clear that in Ireland mental illness poses a health problem of the first magnitude.

While voluntary general hospitals provide limited facilities and private mental hospitals provide approximately 1,000 beds and some out-patient clinics, most of our services, out-patient and residential, are centred on a number of district mental hospitals {containing approximately 18,000 beds) sited throughout the country. A large number of these district mental hospitals were built in the middle years of the last century. Some new buildings have been provided and some old ones have been adequately renovated, but there are still too many barrack-like structures characterised by large wards, gloomy corridors and stone stairways. Too many also have inadequate facilities and services and lack the purposeful activity and therapeutic atmosphere that are necessary in a modern mental hospital. In the Commission's view, a pattern of services confined to the traditional type of mental hospital would leave unfulfilled the need to diagnose and treat as widely as possible incipient mental illness, to provide in whole or in part treatment in the home or in surroundings akin to the patient's normal mode of living, to provide adequate community services and, in particular, it would leave unbridged the gap between psychiatry and general medicine.

One of the first tasks to which the Commission addressed itself was to consider the exceptional rates of residence in the psychiatric hospitals in Ireland. No clear explanation has emerged. There are indications that mental illness may be more prevalent in Ireland than an other countries; however, there are many factors involved, and in the absence of more detailed research, the evidence to this effect cannot be said to be conclusive. Special demographic features, such as the high emigration rate, the low marriage rate and problems of employment, may be relevant to the unusually high rate of hospitalisation. In a largely rural country with few large centres of population, social and geographic isolations may affect both the mental health of individuals and the effectiveness of the mental health services. The public attitude towards mental illness may not be helpful to the discharge of patients and their reintegration in the community. On all these points, the Commission could do little more than ask questions. To provide answers would demand years of scientific inquiry for which neither the personnel of the Commission nor the time at its disposal would have been adequate. The Commission considers that a greatly expanded programme of research, not only into these social and epidemiological problems, but into other aspects of mental illness in Ireland, is urgently necessary.

In its effort to chart the course that services for the mentally ill should follow, the Commission considered the services available in a number of countries. In none did it find the ideal or what might be regarded as suitable for the present and future needs of this community. In fact, many of the defects in the Irish services are to be found, in one degree or another, elsewhere. The Commission's recommendations are based on what it believes to be the most enlightened and up-to-date psychiatric knowledge and the preventive, diagnostic, therapeutic and post-therapeutic methods that research and practical experience suggest as being best calculated to deal with mental illness in this community.

In the last few decades, psychiatric knowledge and methods have undergone a profound advance; and further progress no doubt lies in the not too distant future. There has been no similar period of time in the past which has seen such a marked improvement in therapeutic practice. The change has been due in part to the therapeutic possibilities opened up by the many pharmaceutical discoveries of recent times; but it has also come from a deeper understanding of the aetiology of mental ailments and of the needs of the mentally ill. As knowledge grows, it may, and doubtless will, be necessary to modify the detailed implementation of some of the Commission's recommendations. Some problems bearing on mental illness—such as the law relating to criminal lunatics—lie outside the Commission's terms of reference and are therefore unexplored in this Report. As to others—such as juvenile delinquency and industrial schools—the Commission recommends that they be made the subject of special studies.

While some of the recent advances in psychiatry are already re-

fleeted in parts of the Irish services, the Commission's recommendations indicate that radical and widespread changes will have to be made if these services are to be brought up to the desired standard. In brief, these recommendations postulate a combination of community services and short-term and long-term hospital treatment.

A successful programme for mental health requires the inculcation throughout the community of the basic principles of mental hygiene and an appreciation of, and sympathy with, mental illness and its problems. Many patients can now be successfully treated while living at home or continuing with their work. The Commission's recommendations, therefore, envisage a positive programme of public education, especially for those most likely to come into contact with the mentally ill; services for certain classes, such as children, adolescents and others who may be in need of special care ; the development of community services such as out-patient clinics, day hospitals, hostels, family care, domiciliary consultations; the use in the community, not only of psychiatrists, but also of general practitioners, psychologists, nurses, psychiatric social workers, social workers, voluntary organisations and public health personnel; the development of preventive services and facilities for research, and the co-ordination of all these services with the general programme of preventive and curative medicine.

The capacity of modern psychiatry to give good results with intensive and comprehensive in-patient treatment in a great number of cases, together with the desirability of providing such treatment within the ambit of general medicine, has led the Commission to recommend the setting up of short-term residential units in, or in association with, general hospitals. Such units would require to be adequately staffed and equipped, to be associated with the community services of a particular area, to be ready to treat all types of mental illness requiring short-term in-patient care, and to work in close conjunction with the other psychiatric services and with the general hospital. The Commission considers that the siting of these units at, or their association with, general hospitals would benefit both the unit and the general hospital and would be a valuable step towards creating a link between psychiatry and other forms of medicine.

For the patient requiring long-term treatment, the Commission recommends the development of long-term hospitals fulfilling a positive and creative role. The aim will be to provide active treatment as well as residential care, to rehabilitate and restore to the community as many patients as possible, and to provide for all patients lives as full and happy as their disabilities permit. Such hospitals and the short-term units should be complementary to each other, and both should be linked with full community services. The Commission's recommendations deal with the services and facilities. in terms of staffing, amenities, purposeful work and activities, and after-care, that should go with such hospitals, so as to ensure due respect for the innate dignity of the patient as an individual and the maximum opportunity for his rehabilitation.

Implicit in the Commission's recommendations is the integration

of psychiatry with general medicine. The isolation from other forms of medicine in which psychiatrists have worked in the past is seen as undesirable and unnecessary. There is nowadays a growing appreciation of the affinities of the problems of the mentally and physically ill and a realisation that the mental and physical components of illness are frequently overlapping or complementary. The services recommended will require a considerable amount of team work, involving not alone psychiatrists but also psychologists, nurses, psychiatric social workers, and other specially trained persons. There is, at the moment, a shortage of psychiatrists and certain types of paramedical personnel, and the Report deals with the need for them and the question of their training.

The general medical practitioner will have a particularly important part to play. It is he who is most likely to have the first opportunity of seeing the patient and diagnosing his problems, and it is he who may have the best opportunity of observing the patient's progress after hospital treatment. It is desirable that he should, as far as possible, be closely associated with the patient's care. The Commission is of opinion that the place accorded to psychiatry at present in the curricula of our medical schools is inadequate to enable doctors in general, and general practitioners in particular, to take their proper part in the psychiatric services. The Commission recommends changes in medical education which should ensure that every medical graduate will have an adequate training in psychiatry and a due appreciation of the importance of the human personality in medical theory and practice.

The measures recommended in this Report will require the co-operation of the Department of Health, local health authorities, universities, medical schools, hospital managements, the medical profession, nursing authorities, trade unions, rehabilitation and welfare organisations and other special groups. But they will need, especially, the co-operation of the public at large. Without its enlightened, sympathetic support, no programme promoting community mental health can be successful. The public must he helped to appreciate that mental illness is, in most cases, increasingly amenable to short-term treatment and that early diagnosis and treatment give the best results. The public should be made familiar with the existence of the range of available services and encouraged to make use of them. The spread of balanced and accurate information on the nature, causes and treatment of mental illnesses will help to break down vestigial fear and distrust, to encourage people to come forward for treatment, and to promote help and understanding for those receiving it. The Commission considers that the formation of enlightened and constructive attitudes throughout the community will need a full prog-s'™?? °/ P ^ 1 1 ^ ^ 0 " . Such a programme, directed by the ^Wkil ^^ and. makin S <*«*ive «se of the press, radio and ^ ^ ^ J ^ ^ f ^ ^ ***** " " ^ * the Specific recom-'Sfwh t p S Rcp o ?*Te to * brou S ht ^ early frSon.

The White Paper on The Health Services and their Further De-

velopment", issued by the Government in January, 1966, indicates that considerable changes are contemplated in the financial and administrative structure of the health services generally. The Commission is of the opinion that the improved and extended services outlined in this Report can be incorporated without difficulty into the general framework proposed in the White Paper. It considers, however, that two separate organisations should be established to deal with the special needs of the mentally ill. The first of these is a small, expert National Advisory Council, which, on its own initiative or at the request of the Minister, would provide advice on any matters relating to the mental health services. Many of the services and facilities provided for the mentally ill are being replaced by new techniques, and such a Council would provide expert advice and guidance on questions of their adoption. The other is a National Voluntary Organisation which would be representative of all workers and associations concerned with the care of the mentally ill and whose prime function would be to ensure that the needs and rights of the mentally ill are at all times kept before the public mind.

These are the principal lines on which the Commission feels that change should be set under way. In *Chapter 1,* the Report traces briefly the historical development of services for the mentally ill in Ireland. *Chapter 2* describes recent trends in the care of the mentally ill and explores the present emphasis on community care and on the integration of psychiatry and general medicine. *Chapter 3* sets out the existing pattern of services and discusses Ireland's abnormally high mental hospital population. The remaining chapters set out the Commission's recommendations for improvement and expansion of the psychiatric services.

(B) DETAILED STATEMENT OF COMMISSION'S RECOMMENDATIONS

The Commission's main recommendations are summarised in detail in the following paragraphs. (Cross references are to paragraphs in the Report).

CHAPTER 4—IN-PATIENT CARE

The Commission decided that, in general, a different approach and different forms of treatment are required by short-term and long-term patients.

(a) SHORT-TERM CARE

The expansion of the scope of psychiatry, the emphasis on active and early treatment of mental illness and the appreciation of the need to integrate psychiatry and general medicine have led to the concept of psychiatric units in, or associated with, general hospitals. Such units have considerable advantages provided that positive steps are

taken to obviate the disadvantages which can arise. Planning should aim at the closest possible integration of psychiatry with general medicine.

The Commission, therefore, recommends that:—

(1) Short-term residential treatment should be provided in specially organised units at general hospitals, or in such units operated in close association with general hospitals [P. 37].

(2) The units should cater for all forms of mental illness requiring short-term in-patient care (other than certain special forms discussed in chapter 6) [P. 39].

(3) The work of the units should be closely associated with other forms of psychiatric care, particularly community care and long-term care [P. 38].

(4) The units should provide the full range of treatments and facilities normally available in a psychiatric hospital. Every unit should cater for a specific area. Day hospital facilities should be provided where possible [P. 40, 41].

(5) Pending experience of the operation of the unit already established at Waterford, units should be planned on the basis of a bed need of .5 to 1 per 1,000 of the population of the area served [P. 40].

(6) Staffing should be comprehensive and include, in addition to psychiatrists and psychiatric nurses, such ancillary staff as social workers, occupational therapists and psychologists. The specialist staff of the general hospital should be freely available to the psychiatric unit. Similarly psychiatric and ancillary staff should be available to the general hospital patients [P. 42].

(7) In places where there are already units suitable for short-term care and there is a general hospital within a reasonable distance, use should be made of the existing units, but they should be operated in close liaison with the general hospital.

The Commission considers that in these cases the provision of new units would not be justified [P. 43].

(8) In areas where there are not suitable units, or where there is not a general hospital within a reasonable distance of an existing unit, new units should be provided in or at a general hospital. Where it is not feasible to provide them in or at a general hospital they should be located as near as possible to, and should be operated in close liaison with, a general hospital [P. 43-46].

(9) A psychiatric unit should be provided at the Regional Hospital in Galway [P. 47].

(10) In Dublin, short-term care should be based on the units which already exist in the mental hospitals but much closer links than those existing at present should obtain between the general hospitals and the psychiatric units [P. 48],

(11) In Cork a psychiatric unit of not less than 50 beds should be provided at the new Regional Hospital which is being planned. An additional unit or units containing about 240 beds will also be required. In Cork City, as in Dublin, short-term care should be based, for the present, on the units at Our Lady's Hospital and at Sarsfield's Court, but these units should be operated in close liaison with general hospitals. A unit should be provided at Bantry in lieu of the temporary unit at Skibbereen [P. 49].

Ob) LONG-TERM CARE

As with short-term care the ultimate aim should be the close integration of the services provided for both physical and mental illness. In many countries greatly increased emphasis is being placed on the active treatment of long-stay patients and hospitals for their care are regarded as rehabilitation centres and not merely as centres for custodial care. The aim is to rehabilitate and restore to the commumty as many patients as possible; for those who cannot be restored to the community the aim is to provide as full and happy a life as their disabilities permit.

The Commission recommends that:—

(12) Hospitals, adequately staffed and equipped, should be developed for psychiatric patients requiring long-term care. The staff should include senior and junior psychiatrists, consultants from other branches of medicine, adequate paramedical and nursing staff, instructors, and placement officers and other workers concerned with the rehabilitation of the patient and his preparation for return to the community. General practitioners from the area should be employed as part-time clinical assistants [P. 50-51].

(13) Planned and purposeful activity should be a feature of every long-stay hospital.

Activity can take the form of recreation including the pursuit of hobbies, work of various kinds, training and education [P. 52].

(14) Properly organised recreational activities should be available in every hospital. It should be clearly recognised that recreation is not provided merely for the amusement and entertainment of patients, but is an important part of their treatment [P. 54].

(15) Provision should be made for a wide range of work activities.

It should be borne in mind that work is part of treatment; its aim is to help the patient towards recovery—to teach him work habits which he may have lost or never acquired, to assist him to mix with and co-operate with others, to correct unusual patterns of behaviour, to give a sense of responsibility or of confidence which may have been lost, to restore physical abilities, to create interest and to teach new skills [P. 55].

(16) The work to which a patient is assigned should be determined by his medical, social and psychological needs and should be changed as these needs change [P. 55].

(17) Hospitals which consider they can develop industrial therapy projects to rehabilitate long-stay patients should be encouraged to do so. One or two units should be developed on an experimental basis outside mental hospitals. The aim of these units should be to complete, in appropriate cases, the industrial therapy begun in the hospital and to fit patients for work in the community. The units should be operated in very close association with a mental hospital and, where necessary, hostel accommodation should be provided by the hospital [P. 57].

(18) Facilities for habit training (care of dress, person, table-manners, etc.) should be provided in every long-stay hospital [P. 58].

(19) The present system of payment for work done should be continued and extended [P. 59].

(20) Sheltered workshops should be organised for those patients who require residential care for an extended period and who are not capable of working in the community but who are capable of undertaking employment in which they are not subject to competition from non-handicapped workers [P. 60].

(21) Every health authority should ensure that placement services, with properly trained staff, are available in its area [P. 61].

(22) Every effort should be made to preserve the individuality of the patients and to encourage them to accept responsibility and to use initiative. Practices which tend to reduce the morale of patients should be abolished. Grouping of patients in large masses should be avoided and hospitals exceeding 750 beds should be divided up into more manageable units [P. 62-63].

(23) The closest possible liaison should be maintained between centres providing short-term care and long-term care. There should be clear overall direction of medical policy to ensure that the units complement each other as part of a comprehensive service [P. 64].

(24) The aim should be to reduce the present estimated total of 10,000 long-stay places to approximately 5,000 over the next 15 years.

The Commission is satisfied that, with increased emphasis on community care and on active treatment and early discharge of patients, there will be a considerable reduction in the number requiring long-term residential care. It is impossible, however, to say what will be the extent of the reduction ; the figure of 5,000 *is a target figure only. For the present about* 10,000 *beds of good hospital standard are required for long-term mentally ill patients.* [P. *66.]*

(25) The greatest possible use should be made of existing district mental hospitals. Every health authority should have its existing mental hospital accommodation surveyed by experts to determine—

(a) what buildings are suitable for retention on a short-term and on a long-term basis,

(b) what improvements are necessary and what additional facilities are required at the buildings to be retained, and

(c) what buildings need to be replaced [P. 67].

(26) When new buildings are required the desirability of placing them at a general hospital should be considered.

The Commission accepts the concept of the comprehensive hospital and it considers that, where feasible, there should be integration of psychiatry and general medicine at all levels [P. 67].

(c) PRIVATE MENTAL HOSPITALS AND HOMES

There are 13 private (as opposed to public or health authority) hospitals and homes. At present they are regarded, in many respects, as a homogeneous group, but they vary to a great extent in size and in the scope and nature of their activities.

The Commission recommends that:—

(27) Private institutions should be classified either as psychiatric hospitals or psychiatric nursing homes, in accordance with the type of service provided [P. 69].

(28) Subject to certain conditions, private psychiatric hospitals should be treated, for the purposes of the health services, in a similar manner to voluntary general hospitals. Their contribution and potential should be taken into account when determining the extent of the services which it is necessary for health authorities to provide [P. 70].

(29) Psychiatric nursing homes should be treated in the same way as nursing homes for the physically ill except that, in view of the nature of mental illness and the fact that many patients require treatment over a relatively long period, contributions from health authorities should be paid for a period of 13 weeks [P. 71].

CHAPTER 5—COMMUNITY SERVICES

In recent decades, there has been a growing appreciation of the fact that institutional life can be disabling in its effects—emotionally, physically and socially—and that many patients can be treated, with increased prospects of success, in their normal social environment. The success of community care, however, depends on the development of a number of special facilities within the community.

The Commission recommends that:—

(30) The extensive development of out-patient services should be given a high priority in the programmes of health authorities. Evening clinics should be provided to cater for patients at work during the day [P. 73].

(31) Domiciliary psychiatric consultations should be provided on a limited scale [P. 74].

(32 Day hospital facilities should be provided at the short-stay units and at the long-stay units at mental hospitals as well as at psychiatric units attached to general hospitals. As an initial measure, two independent day hospitals should be provided—one in Dublin and one in Cork. The provision of further independent day hospitals should be considered in the light of experience gained in the operation of these two hospitals and the day hospital recently established in Dundalk [P. 75].

(33) Each health authority should employ sufficient psychiatric social workers and social workers to meet the needs of its area. A psychiatric social worker should be responsible for the co-ordination of social work for psychiatric patients. Nurses and social workers should be aware of the complementary nature of their roles in relation to patients in the community [P. 76-77].

(34) Provision should be made for a system of family care, properly organised and supervised and closely linked with the general scheme of psychiatric services [P.78-80].

(35) A limited number of hostels should be provided, on an experimental basis, in the larger centres of population.

The Commission regards the provision of hostels as very aesirable.provided that they are integrated in the overall pattern of care. [P. 81]

(36) General practitioners should be encouraged to take a greater interest in psychiatry and to undertake a more active role in the treatment of psychiatric patients. General practitioners in the area should be appointed as clinical assistants in psychiatric hospitals, particularly in long-stay hospitals, to assist in the psychiatric, as well as in the physical, care of patients [P. 82].

(37) Community services for the mentally ill should form part of, and be co-ordinated with, the general programme of preventive and curative medicine. Public health personnel should play a far greater part than they have played heretofore in the promotion of mental health and in the provision of services for the mentally ill [P. 83],

(38) Voluntary organisations providing assistance for pyschiatric patients should be encouraged to develop close associations with health authority and other personnel providing psychiatric services.

The Commission considers that there is enormous scope for voluntary organisations in the care of the mentally ill, but they need the backing and guidance of experts. [P. 84].

(39) Clubs should be developed for psychiatric patients who have been discharged from hospital. Such clubs should work in co-operation with the psychiatric services. Social workers should encourage and assist them as much as possible [P. 85].

(40) The payment of Disabled Persons Maintenance Allowances forms an effective and convenient system of providing financial support for mentally ill patients in the community and the widest possible use of the system should be made in future [P. 86].

CHAPTER 6—PROVISION FOR SPECIAL CLASSES

The services already suggested will provide for the majority of the mentally ill but there are some for whom special provisions are necessary. These include children, adolescents, certain aged persons, alcoholics, drug addicts, sexual deviates, epileptics, psychopaths, persons in custody and homicidal and very violent patients.

(a) CHILDREN

Children may suffer from mental illnesses requiring varying degrees of psychiatric care. Detailed statistics of the number of such children in this country, or indeed in any country, are not available. The Commission suggests that the aim should be to provide certain basic services ; as these services are developed the actual needs will become

clearer and, if the provisions suggested are found to be inadequate, they can be increased.

The Commission recommends that:—

(41) Child psychiatric services should be developed on the basis of providing the equivalent of at least one Child Guidance Team per 100,000 of the population of all ages [P. 89].

(42) District child psychiatric clinics should be developed in conjunction with clinics for adults but should be held at different times [P. 90].

(43) Any doctor should have the right to refer a child directly to a district psychiatric clinic [P. 91].

(44) Regional child psychiatric clinics should be developed to deal with cases presenting particular difficulty, or requiring facilities not available at the district clinics. The existing clinics in Dublin should be provided with any additional facilities required to enable them to act as regional clinics. Three additional regional clinics should be provided outside Dublin [P. 92].

(45) Residential accommodation of 4 types should be provided :—

(i) short-term units, mainly for diagnosis and assessment,

(ii) long-term units, mainly for psychotic and severely disturbed children,

(iii) medium-stay units, mainly for emotionally disturbed children,

(iv) units for children with psychosomatic disorders [P. 93].

(46) A system of foster care and family group homes should be developed as an alternative to residential units [P. 94].

(47) Additional provision, in special schools and classes, should be made for children who suffer from psychiatric disabilities and are unable to benefit adequately from the normal school curriculum.

School Attendance Boards should be encouraged to consult the staff of the child psychiatric clinics when dealing with children who consistently fail to attend school [P. 95].

(48) Psychiatric reports should be available to the Courts in respect of children who appear repeatedly before them charged with offences, children whose actions appear irrational and, in particular, children whom it is proposed to commit to a residential centre.

Psychiatric and psychological services should be available in industrial schools. The whole problem of industrial schools should be examined [P. 96].

(b) ADOLESCENTS

Many adolescents can suitably be catered for by the services for children. Some can suitably be catered for by the services for adults, but there are some for whom special provisions are necessary.

The Commission recommends that:—

(49) Specialist staff in the psychiatric services should, where necessary, provide advice and assistance for parents and others concerned with the counselling of adolescents. Psychiatric advice for adolescents should be provided at the district or regional child psychiatric clinics, or at adult clinics—whichever are most appropriate [P. 99].

(50) The development of youth organisations should be encouraged and those in charge should have special regard to the needs of adolescents with emotional or other psychiatric problems [P. 100].

(51) Approximately 150 residential places, located in a few regional centres, should be provided to cater for the special needs of adolescents who cannot suitably be accommodated in centres for children or in those for adults [P. 101].

(52) As in the case of children, psychiatric and psychological services should be available in respect of certain adolescents who appear before the Courts and in respect of those detained in reformatories and industrial schools. The Inter-Departmental Committee on the Prevention of Crime and Treatment of Offenders, or a separate body, should examine the whole problem of juvenile delinquency [P. 102].

(c) THE AGED

The recent White Paper on the " Health Services and their Further Development" indicated that the Government's general aim is to encourage old people to stay at home and to try to ensure that assistance will be available, where needed, to enable them to do so without experiencing hardship, or imposing too great a burden on their relatives. The Commission agrees with this aim. The services already outlined will cater for many of the psychiatric needs of the aged, but some special provisions are necessary.

The Commission recommends that:—

(53) Assessment Geriatric Units should be available where the condition of aged persons can be fully assessed from the physical, psychiatric and social aspects before an appropriate programme of care is formulated [P. 104].

(54) The aim should be to detect and treat mental illness at the

earliest possible stage. Persons dealing with the general care of the aged should be trained to recognise the symptoms of mental illness and should be fully aware of the range of psychiatric services available [P. 105],

(55) There should be close liaison and co-operation between the staff and organisations dealing with the general problems of the aged and those dealing with their psychiatric problems [P 106].

(d) ALCOHOLICS

Alcoholism is a disease and constitutes a major health problem in many countries. No firm conclusions about the prevalence of alcoholism in Ireland can be drawn from available statistics, but the Commission is satisfied, on the basis of the experience of psychiatrists practising in Ireland and daily dealing with the effects of alcoholism, that it is a very serious problem and requires immediate attention.

The Commission recommends that:—

(56) Treatment of early or uncomplicated cases of alcoholism should be undertaken in the community by general practitioners working in close association with psychiatrists [P. 109].

(57) General practitioners should be trained to have a deeper understanding of alcoholism [P. 109].

(58) Officially sponsored seminars for family doctors should be organised in residential treatment units [P. 109].

(59) Social workers should be available for follow-up work in the community [P. 109].

(60) Psychiatric advice and treatment should be provided at out-patient clinics [P. 109].

(61) Special units should be provided for alcoholics in need of residential care. In addition to centres in Dublin, units should be provided at Cork and Gal way [P. 110].

(62) All alcoholics should be advised of the benefits which can accrue from membership of Alcoholics Anonymous [P. 111].

(63) Sample surveys of Irish drinking habits and of the probable prevalence of alcoholism should be undertaken to assess the nature and extent of the problem. A reasonable proportion of the cost of such surveys should be borne by the State [P. 112].

(e) DRUG ADDICTS

Drug addiction, fortunately, is not an extensive problem in Ireland at present. There has been, however, a considerable growth of

addiction in other countries in recent years and continuous effort is required to prevent such growth in this country.

The Commission recommends that:—

(64) Constant vigilance should be maintained to ensure that the existing Regulations for the control of the sale of drugs are kept up to date and that any defects in the Regulations are rectified without delay [P. 114].

(65) A special unit, which would cater for all those in need of residential care, should be established in a short-term psychiatric hospital in Dublin [P. 115].

(f) EPILEPTICS

Epilepsy is a common condition. It is associated with many forms of mental illness, but by no means all epileptics are mentally ill. However, many who are not mentally ill and who do not obtain treatment, or fail to respond to it, develop anti-social tendencies. These persons are frequently admitted to psychiatric hospitals because facilities are not otherwise available for them, or because their anti-social behaviour makes it difficult to provide effective treatment in any other setting. If more facilities were available outside mental hospitals the numbers which have to be admitted would be less and the disabilities of many other epileptics would be considerably reduced.

The Commission recommends that:—

(66) The problem of epilepsy in the country should be examined [P. 116].

(67) Special units for the detailed diagnosis of epilepsy should be established. The diagnostic units should provide expert advice for those dealing with epileptics in the community. *// appears to the Commission that three diagnostic units would serve the whole country. Dublin, Cork and Galway are probably the most suitable centres* [P. 117].

(68) Epileptics who require long-term residential care in a psychiatric setting should be catered for in the ordinary mental hospitals [P. 118].

(g) PERSONS IN CUSTODY

"Criminal lunatic" is a legal term applying to certain mentally ill persons who are in custody. Some have never been tried and may not have committed any crime; others may have committed offences of a minor nature. The Commission regards the term "criminal lunatic" as most unsuitable and completely inconsistent with contemporary psychiatric concepts. It refers to the class of patients

concerned as " custody patients ". At present some custody patients are detained in the Central Mental Hospital at Dundrum; others are detained in district mental hospitals.

The Commission recommends that:—

(69) The Central Mental Hospital should be retained as a special hospital for those custody patients who cannot be suitably catered for in the ordinary range of psychiatric hospitals [P. 126].

(70) The main factors which should be taken into account in deciding whether a particular patient should be sent to, or should be retained in, the Central Mental Hospital should be whether:—

(a) it is possible, without detriment to his psychiatric treatment or the psychiatric treatment of other patients, to provide in the appropriate district mental hospital the degree of confinement regarded as expedient for non-medical reasons ;

(b) his presence in the appropriate district mental hospital would unduly stigmatise the hospital;

(c) there are facilities in the Central Mental Hospital for his psychiatric care which would not be available at the appropriate district mental hospital [P. 126].

(71) Improved psychiatric services should be provided for prisoners who are not custody patients, but who need psychiatric advice or treatment. Prisons and detention centres should make arrangements with the appropriate local health authorities to provide the necessary psychiatric services [P. 127].

(h) HOMICIDAL AND VERY VIOLENT PATIENTS

Some patients in district mental hospitals are homicidal or very violent. The number of these is small, but their presence can create serious difficulties and have adverse effects on the hospital and on other patients. At present they can be transferred to the Central Mental Hospital only by a legal procedure and after they have committed an indictable offence.

The Commission recommends that:—

(72) A system should be established for transferring to the Central Mental Hospital, on medical certificate, those homicidal and very violent patients whose behaviour is such that they cannot be catered for in the ordinary range of psychiatric hospitals [P. 129].

(j) PSYCHOPATHS

The psychopathic personality is characterised by a failure to develop a sense of responsibility and the power of self-restraint. Treatment consists of social training, discipline and education by methods which require special experience and skills.

The Commission recommends that:—

(73) A special unit, of about 50 beds and providing varying degrees of security, should be established in the Central Mental Hospital, Dundrum, to cater for the residential needs of psychopaths from the country as a whole. This unit should cater primarily for aggressive types but it should eventually become a research unit for all categories of psychopathic patient [P. 131].

(74) As experience in dealing with the problem grows, consideration should be given to the possibility of establishing further regional units specialising in the treatment needs of non-aggressive psychopaths [P. 131].

(k) PERSONS APPEARING BEFORE THE COURTS

Crime in adults may be a symptom of emotional disturbance or other psychiatric disorder.

The Commission recommends that:—

(75) The Courts should be in a position to obtain a full psychiatric report in any case where there is any evidence to suggest that mental illness may have a bearing on the crime with which a person is charged [P. 132].

(76) In appropriate cases, consideration should be given to the imposition of a suspensory sentence, on condition that the defendant enters into recognisances to avail of such psychiatric treatment as may be stipulated by the Court [P. 132].

(l) SEXUAL DEVIATES

Sexual deviates are not necessarily mentally ill, but they are a vulnerable group who may be in need of help. At present the main form of treatment is proper counselling. This counselling can be provided at psychiatric clinics.

The Commission recommends that:—

(77) Parents, teachers, general practitioners and other persons who may be aware of individual cases which would warrant psychiatric intervention should try to ensure that the persons concerned attend at the local psychiatric clinics [P. 134].

(78) Psychological and psychiatric reports should be available to the Courts when dealing with sexual deviates [P. 134].

CHAPTER 7—PREVENTION AND RESEARCH

PREVENTION

All treatment services have a preventive aspect. Concentration on these aspects and the institution of specific preventive measures are necessary to reduce the enormous impact of mental illness.

The Commission recommends that:—

(79) In educational measures emphasis should be laid on the preventive aspects of psychiatry and on the need for community effort in which professional workers in all disciplines co-operate with one another and with the general public in the prevention of mental illness [P. 137].

(80) Every effort should be made to inculcate in all those dealing with children and adolescents a sound grasp of the principles of mental health. District and regional psychiatric clinics should be ready at all times to provide advice in cases where problems or difficulties arise [P. 138],

(81) Courses in the principles of mental health should be provided for youth leaders and all those concerned with youth organisations [P. 139].

(82) Children and adolescents whose background makes them particularly vulnerable should receive special attention—particularly from general practitioners and public health personnel [P. 140].

(83) Training in civics should be extended to national schools [P. 141].

(84) The development of vocational assessment and career guidance services should be encouraged in every way [P. 142].

(85) Adults whose circumstances make them particularly vulnerable should receive special attention from all health workers, and the staff of the psychiatric services should be ready at all times to provide advice and counsel. Maternity patients require special consideration and psychiatric clinics or facilities for consultation should be provided at all maternity hospitals [P. 143].

(86) Courses of instruction in preparation for retirement should be organised [P. 144],

(87) In educational measures, stress should be laid on the preventive aspects of early tre^mant (secondary prevention)

and all health personnel should be trained to recognise the early signs of mental illness [P. 145].

(88) In the training of psychiatric staff, stress should be laid on tertiary prevention, so that the rehabilitation of the patient will always be borne in mind [P. 146].

RESEARCH

Despite the enormous impact of mental illness, research into treatment, into the efficacy of different forms of care and into causes and possible methods of prevention are practically non-existent in this country. The Commission considers it essential that such research be carried out. In many other countries an appreciable part of mental health expenditure is devoted to research.

The Commission recommends that:—

(89) Health authorities, the Universities and various other agencies, such as the Medical Research Council, should carry out psychiatric research [P. 150].

(90) The Medico-Social Research Board, or some other suitable organisation, should be given the task of co-ordinating research projects in the psychiatric field. It should itself, or in co-operation with other bodies, or with individuals, arrange for specific schemes of research [P. 151].

(91) The Minister for Health, health authorities, the National Advisory Council and other interested bodies and individuals should suggest suitable subjects for research [P. 151].

(92) The Minister for Health should provide funds for research [P. 151].

CHAPTER 8—EDUCATION AND TRAINING

The quality of a mental health service ultimately depends on the availability of adequate and well-trained staff to operate it effectively. In the development of psychiatric services, therefore, it is essential that priority should be given to the education and training of professional staff and that a considerable part of available resources should be devoted to this work. In addition to professional staff, there are many members of the general public, such as clergy and teachers, who can make a major contribution to the psychiatric services, provided they have an adequate appreciation of the needs of psychiatric patients.

(a) MEDICAL EDUCATION

The Commission considers that the time allotted to psychiatry in the curricula of the various medical schools is inadequate in relation

to the importance of the subject in medical practice. The emphasis is on physical medicine to the virtual exclusion of psychological medicine, in which subject the instruction given does not produce an adequate appreciation of the importance of social and psychological phenomena. There is insufficient staff available for teaching. There is a Chair of Psychiatry in one school only and even this is a part-time post. Due to the lack of proper teaching, medical practitioners in general are not sufficiently aware of the broad principles of modern psychiatry to make an effective contribution to the psychiatric services. Facilities for post-graduate education in psychiatry are also very inadequate. Three of the medical schools offer a Diploma in Psychological Medicine, but two of these do not offer any course of instruction. In relation to training and experience, all three simply prescribe service of any kind in a mental hospital.

The Commission recommends that:—

(93) A wholetime Chair in Psychiatry should be established in each of the medical schools [P. 154].

(94) The following principles should be adopted to ensure that an adequate programme of undergraduate education is developed:—

(i) Psychiatry should be taught as a major clinical subject.

(ii) In courses of instruction in animal and human biology due emphasis should be given to human behaviour in its psychological and social as well as its physiological aspects.

(iii) For effective instruction in psychiatry students should be organised into small discussion groups.

(iv) The curriculum should incorporate a course devoted to the evolution of human personality and its characteristics during different stages of the life span.

(v) Students should undertake a full-time clerkship in clinical psychiatry [P. 154].

(95) There should be a combined effort by the medical schools offering post-gradu'ate education in psychiatry to provide a proper programme in which carefully supervised experience will be gained and a wide range of instruction given and in which the student will obtain a variety of clinical experience and be exposed to the influence of a number of teachers **[P. 155].**

(b) PSYCHOLOGISTS

In this country very few psychologists are employed in the psychiatric services. In other countries the psychologist is frequently a member of the mental health team. The Commission is of opinion

that the present output of psychologists will have to be increased to meet the expanding services for the mentally handicapped and the mentally ill.

The Commission recommends that:—

(96) A University course, embracing laboratory work and supervised clinical experience, as well as a full grounding in academic psychology, or the equivalent of such a course, should be regarded as the necessary qualification for psychologists who practise in the psychiatric field [P. 157].

(c) PSYCHIATRIC NURSES

An Bord Altranais controls the registration, training and certification of nurses within the State. At present the training of psychiatric nurses is separate from that of general nurses There is a noticeable international trend towards the introduction of a common basic training for all nurses, followed by specialisation in particular fields. There appears to be no immediate prospect of introducing such a system in Ireland, but steps towards a closer integration of general and psychiatric nurse training are possible. Some minor changes in the present system of training are also desirable.

The Commission recommends that:—

(97) Joint training schemes, in neighbouring approved psychiatric and general hospitals, should be established on an experimental basis [P. 161].

(98) The training period for qualification should be reduced to 18 months in the case of general trained nurses undertaking psychiatric training and of psychiatric nurses undertaking general training [P. 161].

(99) All nurses undergoing general training should spend a period of at least three months full-time training and instruction in accordance with an approved syllabus in a psychiatric hospital [P. 161].

(100) All nurses undergoing psychiatric training should spend a period of at least three months full-time training and instruction in accordance with an approved syllabus in a general hospital, preferably a hospital incorporating a training school [P. 161].

(101) Training schools for psychiatric nurses should be regularly reviewed or inspected to ensure that they comply with the standards laid down by An Bord Altranais. Should they fail to achieve the required standards they should be struck off the list of training schools [P. 162].

(102) Where hospitals fail to provide suitably organised introductory courses for student nurses, consideration should be given to the provision of such courses for groups of hospitals at suitable regional centres [P. 162].

(103) The minimum age of entry for student psychiatric nurses should be reduced to 17 years. While it is hoped that, ultimately, the Secondary Schools' Leaving Certificate will be specified as the minimum educational qualification the Intermediate Certificate (or its equivalent) should be stipulated as the minimum educational level for the present [P. 163].

(104) Because of the increasing emphasis on domiciliary care, instruction about the social services and out-patient and domiciliary work should be included in the curriculum of the student nurse [P. 164].

(105) Refresher courses should be organised regularly for both senior and junior qualified psychiatric nurses [P. 165].

(106) Suitable library facilities should be provided in every psychiatric hospital [P. 166].

(107) Courses to provide training and experience in group leadership and activation should be organised at local centres; training and experience in group leadership and activation should be regarded as equivalent to general training for marking purposes when candidates are being selected for higher posts in the psychiatric services [P. 167].

.(d) SOCIAL WORKERS

Many of the mentally ill require the help of social workers if they are to remain in or be returned to the community. Two main grades are concerned with services for the mentally ill—psychiatric social workers and social workers.

The Commission recommends that:—

(108) Every health authority should employ sufficient social workers and psychiatric social workers to meet the needs of its area [P. 77].

(109) Facilities to train psychiatric social workers should be developed in Ireland [P. 170].

(e) OCCUPATIONAL THERAPISTS

The importance of activity in the mental hospital has been stressed in Chapter 4. The occupational therapist is an important member of the team dealing with the activation of patients, particularly long-stay

patients. Hitherto very few occupational therapists have been employed in the psychiatric services, but that position is being rectified. A Course leading to a Diploma in Occupational Therapy was established in St. Joseph's College of Occupational Therapy, Dun Laoghaire in 1963 and the first Diplomas have now been awarded.

The Commission recommends that:—

(110) Particular attention should be paid to changing conditions in the psychiatric field and any necessary adjustments should be made in the existing course of training in the College of Occupational Therapy [P. 172].

(f) MENTAL HOSPITAL CHAPLAINS

The Commission is satisfied that the mental hospital chaplain has an important part to play in the care of the mentally ill. The selection and training of chaplains are, of course, matters for the relevant ecclesiastical authorities, but the Commission feels that special training in the needs of psychiatric patients would be of great benefit to them in their work.

The Commission recommends that:—

(111) The relevant ecclesiastical authorities should give particular consideration to the training of chaplains and to the role they are to fill in the mental hospitals [P. 173].

(112) Chaplains should be appointed for periods long enough to enable them to establish close working relationships with patients and staff. Because of the arduous nature of the work, the appointment should not be indefinite in time—an appointment period of 5 or 6 years is suggested [P. 175].

(g) THE EDUCATION OF THE PUBLIC

Full support from the community is essential if psychiatric services are to be fully developed. The public has become considerably more enlightened in recent years but much yet remains to be done.

The Commission recommends that:—

(113) A positive programme of public education should be initiated, operating through professional workers in the field of mental health, through key personnel in the community and through the mass media of communication. It should be the responsibility of the Minister for Health to encourage the development of this programme [P. 176].

(114) The various professional workers in the psychiatric field should endeavour to cultivate among the general public a proper appreciation of the problems of mental illness and

the adoption of an enlightened attitude towards it. Professional workers in other health fields should help in this work [P. 177-178].

(115) Teachers should be instructed in child development and in the general problem of mental illness [P. 179].

(116) The relevant ecclesiastical authorities should consider the organisation of additional seminars and courses to provide further instruction for clergy in the basic principles of mental hygiene [P. 180].

(117) In the training courses for Gardai instruction should be given in the behavioural consequences of mental illness and emotional disturbance, particularly in regard to children and adolescents [P. 181].

(118) The professional legal bodies concerned should be encouraged to try to improve the level of informed appreciation among lawyers, of the problem of mental illness [P. 182].

(119) Trade Unions should be encouraged to educate the general body of workers to adopt an enlightened attitude towards mental illness [P. 183].

(120) The authorities in charge of the mass media of press, radio and television should consult expert opinion on all programmes which are likely to affect public attitudes towards mental illness.

This is particularly apposite in the case of television where many imported programmes tend to be sensational in their approach [P. 184].

(121) The press should discharge an educational role by providing informed articles on various aspects of the problem of mental illness [P. 184].

(122) The authorities in charge of television should consider the appointment of an advisory panel of experts to advise on the presentation of programmes which have a psychiatric content and to frame educational programmes in this field [P. 184].

(123) Marriage guidance courses, both pre-marriage and post-marriage, should be extended as widely as possible [P. 185].

CHAPTER 9—ORGANISATION OF SERVICES

There should be no difficulty in incorporating improved and extended psychiatric services in the financial and administrative structure of the health services outlined in the recent White Paper on The Health Services and their Further Development. However, it will be necessary to establish special organisations to deal with certain

aspects of the problem of mental illness and it will also be necessary to make changes in the existing administrative and other staffing structures.

The Commission recommends that:—

(124) A National Advisory Council should be established. The Council should be a small expert body which, on its own initiative, or at the request of the Minister, would provide advice on any matter pertaining to the mental health services [P. 187].

{125) A national voluntary body, similar to National Associations for Mental Health in other countries, should be formed to help to advance the cause of the mentally ill [P. 188].

(126) When long-stay units for psychiatric patients are developed into rehabilitation centres with adequate staff and facilities, they should gradually extend the scope of their activities to include the accommodation, rehabilitation and retraining of certain persons suffering from physical disabilities [P. 189].

(127) The present staff structure in district mental hospitals should be replaced by one more closely resembling that in general hospitals. This is a matter which could be considered by the National Advisory Council [P. 190].

(128) Lay administrators and sufficient clerical and typing staff should be appointed, so that medical and nursing staff will be relieved, as far as possible, of administrative and clerical responsibilities and allowed to concentrate on the duties for which they are trained [P. 191].

(129) The rigid barriers between male and female nursing should be broken down [P. 192].

(130) Female staff should be employed on male wards and male staff should provide services for male and female patients in fields such as the organisation of activity and nurse-administration [P. 193].

(131) There should be one nursing officer with overall responsibility for nursing services in each psychiatric hospital [P. 193].

(132) The requirement that applicants for senior female posts must be qualified in general nursing should be withdrawn [P. 193].

(133) Psychiatric nurses, acting as leaders and activators, should participate with patients in any work or recreational activity which is directly related to the care and rehabilitation of patients—otherwise they should not be employed on non-nursing duties [P. 194].

(134) To foster good relationships between all staffs and to develop a spirit of co-operation and team-work a number of com-

mittees should be appointed in each psychiatric hospital [P. 195].

(135) It should be made possible, in appropriate cases, for patients to obtain treatment outside the administrative areas in which they normally reside [P. 196].

(136) The question whether hospital farms should be retained or not should be carefully reviewed [P. 197].

(137) Health authorities should be subjected to less rigid control in regard to expenditure on the provision of buildings [P. 198].

(138) The Central Mental Hospital should be administered by the appropriate health authority and not by the Minister for Health. The further recruitment of attendants should be discontinued and vacancies should be filled by psychiatric nurses [P. 199].

CHAPTER 10—LEGISLATION

The present code of legislation dealing with the mentally ill is in need of amendment.

The Commission recommends that:—

(139) Existing provisions for the reception and detention of patients requiring residential treatment should be replaced by:—

A.—a system of informal admission on the lines of that used in general hospitals. In the absence of positive objection by the patient or his relatives it should be assumed that the patient is willing to accept the regimen of the hospital and any treatment offered. The informal patient should be at liberty to leave the hospital at any stage on request. Powers of detention not exceeding 72 hours should be given to the hospital medical staff in certain cases to give them an opportunity to acquaint relatives of the patient's intention to leave the hospital and to make alternative arrangements for his care [P. 202].

B.—a system of compulsory admission for patients who cannot be admitted informally. This should provide for detention for an observation and examination period not exceeding 14 days. If the treatment of the patient makes it necessary to do so, the initial period of detention could be extended for a further period **not** exceeding 6 weeks from the date of admission, then for a further period not exceeding 3 months from the date of admission, then for a further period not exceed-

ing 6 months from the date of admission and thereafter for periods not exceeding 12 months on any one extension. Provisions similar to those already in existence for dealing with emergency admissions should be made [P. 203].

(140) The existing remedies for improper detention should be retained [P. 204].

{141) Centres for the residential treatment of the mentally ill should be classified as psychiatric hospitals or psychiatric nursing homes. All centres providing residential care or treatment should be registered and be subject to inspection by the Inspector of Mental Hospitals. The Minister for Health should be empowered to exempt certain centres from inspection [P. 206].

{142) Health authorities should be empowered to provide or to arrange for the provision of sheltered employment for persons who are mentally ill or recovering from mental illness. Where sheltered employment is provided by voluntary agencies, health authorities should be given powers of inspection [P. 207].

{143) The law should be changed so as to allow mental hospital authorities as much freedom as possible in dealing with patients who are Wards of Court, subject only to such control by the Court as may be considered necessary [P. 208].

(144) The provisions in existing legislation requiring the formal designation of hospitals providing psychiatric treatment should be repealed [P. 209].

(145) Legislation should be introduced to give effect to the Commission's recommendations (a) that provision be made for a less restricted form of boarding out, including the removal of the requirement that only one patient can be boarded out in any one dwelling; and (b) that the procedure for transferring homicidal and very violent patients to the Central Mental Hospital should be changed to one of medical certification [P. 210-211].

(146) The existing provisions for absence on parole or trial should be changed to one of absence with permission. Any patient who completes 90 days permissive absence should be discharged [P. 212].

REPORT OF COMMISSION OF INQUIRY ON MENTAL ILLNESS

PRELIMINARY

Terms of Reference

1. The Minister for Health, by Warrant dated 21st July, 1961, appointed the Commission of Inquiry on Mental Illness :—

(a) to examine and report on the health services available for the mentally ill and to make recommendations as to the most practicable and desirable measures for the improvement of these services ;

(b) to consider and report on changes which they regard as necessary or desirable in the legislation dealing with the mentally ill (other than the legislation dealing with criminal lunatics and with the estates of persons under the care of the High Court or the Circuit Court).

Membership

2. Particulars of the membership of the Commission at different stages of the inquiry are in Appendix A. The first Chairman, Mr. Justice Martin C. Maguire, resigned, owing to ill-health, on 19th September, 1962, and was replaced by Mr. Justice Henchy. Mr. Justice Maguire died on 24th September, 1962. Dr. V. G. Crotty died on 13th December, 1964. Mr. N. J. Burke died on 8th April, 1965. We deeply regret the deaths of these three members.

Changes of circumstances made it necessary for three members to resign—Dr. J. P. McCann, with effect from 20th September, 1962, Dr. L. G. Kiloh with effect from 1st October, 1962, and Rev. J. Erraught, S.J., with effect from 2nd April, 1963.

The Commission takes this opportunity to record its appreciation of the very valuable contribution made by all these members to its deliberations.

Procedure

3. The Commission held its first meeting on 31st July, 1961, and held in all 38 meetings, most of which extended over two whole days. In addition, it appointed a number of committees to deal with particular subjects and these committees held a total of 72 meetings. The Commission issued public advertisements inviting anybody who desired to give evidence or make submissions to communicate with the Secretary. Special invitations to submit evidence were issued to a number of organisations and individuals with a particular interest

in the field of mental illness. The Commission heard oral evidence from four and received written submissions from fifty-one organisations and individuals. Lists of these are at Appendix B and Appendix C respectively. The committees also consulted outside experts on various aspects of the problems which they were considering.

The Commission, or representatives of the Commission, visited every hospital and home in the country catering for the mentally ill. Commission representatives also visited County Homes in Carlow and in Athy, Co. Kildare, Heatherside Hospital, Co. Cork, Mountjoy Prison, Portlaoise Prison, St. Patrick's Institution, Dublin, St. Conleth's School, Daingean, and a number of industrial schools. Discussions were held with the authorities of all hospitals and other centres visited. The views and information obtained in the course of these discussions were of considerable help to the Commission.

A cknowledgments

4. The Commission would like to express its appreciation of the help given by the various organisations and individuals with which it came in contact. In particular, it would like to thank those organisations and individuals who gave evidence or made written submissions. All views submitted and representations made were carefully considered.

A list of publications which were of particular value to the Commission is at Appendix D. Individually and collectively the members of the Commission had access to an enormous amount of literature on mental illness and there is little doubt that their deliberations were influenced by a host of authorities. If the Commission has failed to acknowledge any ideas or opinions it has done so inadvertently, and it would like to pay a general tribute to the numerous authors whose writings contributed to Us knowledge of mental illness.

The Commission wishes to thank Dr. F. H. Taylor, Medical Director and Consultant Psychiatrist, Early Treatment Centre, Rednal, Birmingham (formerly Medical Director of Henderson Hospital) who addressed the Commission on the subject of psychopathy. His address was of particular assistance to the Commission in its consideration of this problem.

The Commission is also indebted to the British Ministry of Health, the British General Register Office, and the Manchester Regional Hospital Board for the considerable assistance given to the members of the Commission who visited England to examine statistical methods and to assess the merits of psychiatric units in general hospitals. In particular it would like to thank Dr. G. C. Tooth, Principal Medical Officer of the Ministry of Health, Dr. J. S. B. Mackay, Deputy Senior Administrative Medical Officer to the Manchester Board and Miss E. M. Brooke, Statistician, General Register Office, all of whom spared no effort to ensure the success of the visit.

The members of the Commission living in Ireland wish to record their appreciation of the invaluable help they got from the members

in England (Dr. George Egan, Dr. Otho FitzGerald, Dr. David Kay, Dr. Leslie Kiloh and Professor Martin Roth) who gave unsparingly of their great knowledge and experience.

Arrangement of Report

5. Part I of this report traces briefly the historical development of services and sets out modern trends in broad outline. Part II sets out, again in broad outline, the pattern of services provided in Ireland at present. Part III contains the Commission's recommendations for the improvement and extension of services.

The term Ireland, as used throughout this report other than in the historical sections, excludes the counties of Antrim, Armagh, Derry, Down, Fermanagh and Tyrone, which are referred to as Northern Ireland.

PART I

INTRODUCTION

CHAPTER 1

HISTORICAL

Development of Public Asylums

6. Before and during the Middle Ages, little, if any, special provision was made for the mentally ill. Asylums for their care were first built in Europe about the 15th century, but it was not until the 18th and 19th centuries that they were provided on a large scale. In Ireland the first public provision was made in 1708 when cells were erected in the Dublin House of Industry or Workhouse. In 1711 cells were constructed, adjoining the infirmary of the Royal Hospital at Kilmainham, to cater for soldiers quartered in Ireland who became mentally deranged. Provision similar to that made in the Dublin House of Industry was made later—usually in association with workhouses or jails—in other parts of the country, and accommodation was provided at Cork, Ennis, Lifford, Limerick, Kilkenny, Roscommon, Tipperary, Waterford and Wexford. In 1810 a parliamentary grant was made for an asylum in Dublin, and the institution now known as St. Brendan's Hospital, Grangegorman, was then founded.

These provisions did little more than highlight the extent of the problem of mental illness. The Inspectors General of Prisons, who also inspected asylums up to 1845, stated that " the only public asylums that existed, when we commenced duty in 1821, . . . were those of Dublin and Cork, exclusive of a few private asylums, chiefly in the neighbourhood of Dublin, which are conducted on humane and judicious principles; all others were temporary receptacles for idiots and incurable cases in the jails and houses of industry scattered throughout the country towns, and where no means could be provided for the cure and proper care of such patients". Following the report of a Select Committee of the House of Commons (see paragraph 9) legal provision was made in 1821 for the erection of a number of public asylums. Under this authority a network of district mental hospitals was provided throughout the country between the years 1827 and 1869. Since then only one new district mental hospital has been erected—Ardee District Mental Hospital which was opened in 1933. At present a former tuberculosis hospital in Newcastle, Co. Wicklow, is being converted for use as a district mental hospital and it should open for the reception of patients in the near future. Pressure on accommodation in other areas since 1869 has been met either by additions to the existing establishments or by the provision, within the existing districts, of new hospitals which are branches or departments of the main hospital for the district. Section 76 of the Local Government (Ireland) Act, 1898, authorised the establishment of auxiliary mental hospitals for

chronic and harmless patients, but only one such hospital was provided—Youghal, which opened in 1904. At Appendix 1 is a table showing, in respect of every public mental hospital in the country, the year of opening, the area catered for then and now, the main additions to the original structure, the original patient complement and the complement on 31st December, 1965.

Development of Private Asylums and Homes

7. Private asylums or homes were developed concurrently with the public mental hospitals. The first of these, and indeed the first mental hospital in Ireland, St. Patrick's, James's Street, Dublin, opened in 1745 and is still flourishing. This hospital was founded on a bequest made by Dean Swift who derided his own action in the following words :—

> He gave the little wealth he had
> To build a house for fools or mad,
> To show by one satiric touch
> No nation needed it so much.

Notwithstanding Swift's apparent conviction of the need for accommodation, it is of interest to note that the following extract from the Charter under which the hospital was provided seems to indicate that it was regarded as doubtful whether a sufficient number of mentally ill persons could be found to occupy the building : " and if a sufficient number of idiots and lunatics could not be readily found, he (Dean Swift) directed that incurables should be taken into the said hospital to supply such deficiency; but that no person labouring under any infectious disease should be admitted into the same ".

In 1799 Knockrea (or Cittadella) private asylum was opened in Cork. A number of other private asylums were opened during the nineteenth century. Of those which still remain, Bloomfield Retreat, Donnybrook, Dublin, was opened in 1810; Hampstead House (with which Highfield and Elmhurst are now associated), Glasnevin, Dublin in 1825; Lindville, Cork in 1829; Verville Retreat, Dublin in 1857; St. Vincent's, Dublin in 1858; Palmerstown House, Dublin in 1869; St. John of God Psychiatric Hospital, Dublin in 1882, and Belmont Park, Waterford in 1883. Four additional private hospitals or homes opened in the present century: Carriglea, Co. Waterford, 1904; Kylemore Clinic, Dublin, 1947; St. Augustine's, Ratoath, 1952, and Cluain Muire, Dublin, 1963. Private mental hospitals or homes at present provide accommodation for approximately 1,200 patients.

Prevalence of Mental Illness

8. It is difficult to determine the number of persons who were mentally ill, or who were so regarded, in former times. The annual reports of the Inspectors (see paragraph 10) show the numbers who were in private and public mental hospitals, in poor law institutions, in prisons and at large. However, estimates made of the numbers

at large are of very doubtful validity. In connection with the census for 1851 a return was obtained (chiefly from the police) showing the names, age, sex, marital status, rank, profession and occupation of each person who was regarded as a lunatic or an idiot. Returns were made of 1,073 lunatics and 3,562 idiots. In the report of the Inspectors of Lunatic Asylums for the same year it was stated that there were 3,674 idiots, 931 lunatics and 4,380 epileptic imbeciles at large, making in all 8,985. Commenting on this position, the census report stated that the return of lunatics and idiots made to the Inspectors " was made through the Poor Law Commissioners, by the relieving officers of each electoral division, but the estimate entirely rests on the authority of these officers, who merely stated the numbers they believed existed in their districts without specifying the names, ages, sexes, places of abode or other circumstances of such (persons— all of great importance, if not indispensable, in arriving at the numbers of and condition of any class of the community ". Whether the return obtained for the census was substantially more reliable it is difficult to say, but it is unlikely that the police would be in a position to determine the prevalence of mental illness with any accuracy.

Table A on the following page shows the number of patients maintained in public and private mental hospitals in each 10 year period from 1851 to 1961, and also the total number who, according to the reports of the Inspectors, were maintained in other institutions or were at large. Further details regarding the number of those at present in district mental hospitals or private mental hospitals or homes are contained in Chapter 3.

Committees and Commissions

9. As far back as 1804, a Select Committee of the House of Commons considered provisions for the mentally ill in Ireland. It reported that the demand for admission into houses of industry greatly exceeded the accommodation available and that it did not appear that any institution, maintained in any degree at the public expense, existed in any part of Ireland other than Dublin, Cork, Waterford and Limerick. It recommended that four provincial asylums should be established. A Bill providing for such asylums was introduced but was never enacted.

In 1817, a further Select Committee of the House of Commons suggested that the only mode of effectual relief would be found in the formation of district asylums, exclusively appropriated to the reception of the insane. The Committee proposed that, in addition to asylums which existed in Dublin and Cork, four or five additional asylums should be built, each capable of accommodating 120-150 patients. This report led eventually to the passing of the Lunacy (Ireland) Act, 1821, under which most of the existing district mental hospitals were built.

In 1841, a Committee of the House of Lords was appointed to consider the state of the lunatic poor in Ireland and to report to the House. It proposed that the practice of committing mentally ill

TABLE A

Year	In Public Mental Hospitals	In Private Hospitals and Homes	In Workhouses or in County Homes	In Prisons	Single Chancery and other Patients in Unlicensed Private Houses	At Large	Total	Total Population	
1851	3,004	436	2,393	280		4,635	10,748	6,552,000	
1861	4,422	509	1,655	293	—	7,277	14,156	5,799,000	
1871	6,821	681	2,754	1	—	6,490	16,747	5,412,000	Northern
1881	8,844	622	3,513	3	—	5,491	18,473	5,175,000	Ireland
1891	11,667	621	3,961	2	—	4,970	21,221	4,705,000	included
1901	16,566	709	3,805	—	89	3,868	25,037	4,459,000	
1911	20,771	909	2,571	—	143	4,044	28,438	4,390,000	
1921	15,474	927	1,900 (Est.)	—	150 (Est.)	—	18,451	2,971,992	
1931	17,569	843	1,505	—	167	—	20,084	2,968,420	Northern
1941	19,240	689	915	—	237	—	21,081	2,955,107	Ireland
1951	18,774	891	227	—	187	—	20,079	2,960,593	excluded
1961	19,530	1,064	—	—	—	—	20,594	2,818,341	

persons to jails and bridewells should be discontinued, and it considered it inappropriate that union workhouses or houses of industry should be used for their care or treatment. It recommended the establishment of a centre to care for criminal lunatics and, as a result, the Central Mental Hospital, Dundrum, was erected. The Committee also commented adversely on the degree of overcrowding in centres catering for the mentally ill.

A further Select Committee of the House of Commons reported in 1855. It dealt mainly with the question of financing the provision of asylums.

A Royal Commission was appointed in 1856 to enquire into the state of lunatic asylums and other institutions for the custody and treatment of the insane in Ireland. This Commission stressed the pressing need for additional accommodation. It dealt with various administrative reforms and recommended that parts of the workhouses should be adapted and used for some of the incurable class of patients—this recommendation was not implemented. The Commission was satisfied that the number of district asylums then existing would be found more and more inadequate for the wants of the country.

In 1859, a further Select Committee of the House of Commons was appointed. It stressed the necessity for providing in Irish asylums accommodation for the class immediately above paupers whose friends and relatives were willing to pay a small additional sum for their maintenance.

In 1878, a Lunacy Inquiry Commission was appointed. It considered that portions of some workhouses could be appropriated exclusively for certain mentally ill patients. It noted that overcrowding caused by the increase in the number of incurable patients, which had been commented upon adversely by previous committees, had now reached alarming proportions. It proposed that this overcrowding should be relieved by providing auxiliary asylums. School-buildings associated with certain workhouses were suggested for this purpose. The Committee considered that, for the better care, relief and treatment of the lunatic and idiot poor, the whole lunacy administration should be re-organised.

In 1925, the Minister for Local Government and Public Health appointed a Commission to consider the relief of the sick and destitute poor, including the insane poor. In regard to the mentally ill, the terms of reference were:—

> "To inquire into the existing provision in public institutions for the care and treatment of mentally defective persons and to advise as to whether more efficient methods can be introduced, especially as regards the care and training of mentally defective children, due regard being had to the expense involved ".

" Mentally defective persons " was interpreted to include mentally disordered as well as mentally handicapped persons. This Commission found overcrowding in many hospitals, and it recommended that the excess patients in the mental hospitals and the insane in poor

law institutions should be provided for in auxiliary mental hospitals. It saw no insuperable difficulties in treating incipient forms of mental disease and temporary states of mental disorder in wards in general hospitals, or in establishing dispensaries for out-patients with which medical officers of the mental hospital service would be associated. It suggested that provision should be made to board-out mentally ill patients. It recommended several legislative changes, many of which were incorporated in the Mental Treatment Act, 1945.

Legislation

10. The first public provision for the mentally ill was made under the Poor Law, which established the workhouse system, and many mentally ill persons were catered for under the Poor Law well into the present century. Workhouses were authorised by law as early as 1703 in Dublin and 1735 in Cork. The basis of the Poor Law as it existed prior to the year 1921 was the Poor Relief (Ireland) Act, 1838. Numerous other Poor Law Acts were passed between 1838 and 1921 but the principal features of the 1838 Act remained. Following the establishment of a separate State in 1921, workhouses as such, were abolished and county homes were established in most areas for the institutional relief of the aged and infirm and chronic invalids eligible for relief.

The main legal provisions governing the erection of asylums were contained in the Lunacy (Ireland) Act, 1821. This Act was entitled " An Act to make effectual provision for the establishment of asylums for the lunatic poor and for the custody of insane persons charged with offences in Ireland." It provided for the formation of districts which might include one or more counties or cities or towns. It empowered the Lord Lieutenant with the advice of the Privy Council to direct the erection of asylums in the several districts. It was under the powers conveyed by this Act that virtually all the district mental hospitals were provided. Section 15 of the Central Criminal Lunatic Asylum Act, 1845, gave power to establish an asylum for each of the provinces of Ireland, to be used for any particular class or classes of lunatics. The intention was to establish special asylums for chronic and harmless patients. The power conferred by the Section was not used and it was repealed by the Local Government (Ireland) Act, 1898, Section 76 of which gave power to establish auxiliary asylums " for the reception of chronic lunatics who, not being dangerous to themselves or others, are certified by the resident medical superintendent of an asylum . . . not to require care and treatment in a fully equipped lunatic asylum . . . ." Under the last mentioned provision an auxiliary asylum was provided at Youghal, Co. Cork.

In 1842, the first Act dealing with private asylums was passed. It made provision for licensing and regulating the management of these institutions and for their inspection. The Act did not require charitable institutions, supported wholly or in part by voluntary contributions and not kept for profit by any private individual, to

be licensed. The Act provided that no person could be received into or detained in any private asylum without a medical certificate from two physicians, surgeons or apothecaries.

Under the Act of 1821, the Lord Lieutenant was authorised to make Rules and Regulations for the good conduct and management of asylums. Under these Rules and Regulations the normal method of admission was on the recommendation of a Justice of the Peace accompanied by a medical certificate. Under the Criminal Lunatics Act, 1838, dangerous lunatics, that is, persons "discovered and apprehended in Ireland under circumstances denoting a derangement of mind and a purpose of committing some crime ", could be committed to jail and thence removed by warrant of the Lord Lieutenant to any asylum. This provision had the effect of increasing the number of lunatics in jails and led to serious abuses. The committal of dangerous lunatics to jails was prohibited by the Lunacy Act, 1867, Section 10 of which empowered any two Justices of the Peace to commit to the district lunatic asylum any person apprehended or discovered under circumstances denoting derangement of mind and a purpose of committing an indictable crime. The purpose of the section was to provide a substitute for committing dangerous lunatics to jail, but it came to be very widely used, and up to 1947 the greater portion of poor persons admitted to mental hospitals were committed under this section.

Special provision was made for insane convicts and other criminal lunatics by the Central Criminal Lunatic Asylum Act, 1845. Under this Act a central asylum for 120 criminal lunatics was established at Dundrum, Dublin. The asylum was completed in 1850. At that time no establishment exclusively for the reception of criminal lunatics was known to exist in any country.

The first provision for the inspection of asylums was made in a Prison Act of 1826. This Act provided for the appointment of two Inspectors General who were required " once at deast in every year to go around . . . and visit and inspect every jail, bridewell, house of correction, penitentiary, or other prison, and every madhouse and place where lunatics or idiots are confined, whether the same be a public establishment or kept for profit by any private individual". The Central Criminal Lunatic Asylum Act of 1845, empowered the Lord Lieutenant to appoint one or two Inspectors of Lunatics to whom were transferred the functions of the Inspectors General of Prisons, so far as they related to lunatics.

Under an Act of 1898, a new administrative system was set up and it became the duty of County Councils to provide accommodation for the lunatic poor and manage the asylum for the county. The Councils' powers were exercised through special Committees of Management, which were empowered to make regulations respecting the government and management of the asylums, the admission, detention and discharge of patients, and the conditions as to the payment and accommodation for private patients.

The law governing mental illness continued to be governed mainly

by these statutes up to 1945. In that year the Mental Treatment Act 1945, was passed. This was a comprehensive Act and dealt with all aspects of mental illness other than the care of criminal lunatics and Wards of Court. It provided, *inter alia*, for: —

(i) the formation of mental hospital districts and the appointment of mental hospital authorities;

(ii) the duties of mental hospital authorities regarding the provision of hospitals, treatment, maintenance, advice and services;

(iii) the reception and detention of patients;

(iv) the powers and duties of the Inspector of Mental Hospitals;

(v) the financing of mental hospital authorities;

(vi) the registration of private hospitals;

(vii) the acquisition and disposal of land by mental hospital authorities; and

(viii) the superannuation of staff of mental hospital authorities.

A number of these provisions have been repealed and been replaced by legislation applying to all health authorities and to health services generally. Other provisions have been amended. The Commission discusses in Chapter 10 the extent to which the existing provisions require amendment so as to cater for the improved services recommended in this Report.

CHAPTER 2

TRENDS IN THE CARE OF THE MENTALLY ILL

Ancient Times

11. In ancient times the mentally ill were sometimes regarded as holy men, or as possessed by a good spirit, but more often they were regarded as sinful, or as being under the influence of the devil. They were sometimes treated with great respect and kindness, but more often they were regarded as persons to be punished for their sinful or criminal acts, and were subjected to great cruelty. They were frequently confined under appalling conditions, or were harried from place to place, often abused and tormented. The advent of the asylums did not end their miseries. Many of the early asylums were not so much places of refuge and protection as places for the incarceration and, if possible, subjugation of the mentally ill. Most of them resembled prisons and the patients were regarded as criminals. Chains and fetters were commonplace and various forms of punishment were regarded as necessary. Treatment, in so far as it was attempted, usually consisted of the use of herbs, charms and other superstitious practices, astrology, bleeding, purging, vomiting and various forms of castigation. Evidence on the treatment of patients in Ireland was given to the Select Committee established in 1817 (see paragraph 9). One witness stated that when he visited Clonmel asylum in 1814-15 the patients were not clothed; some were lying in the yard on the straw in a state of nakedness. At Limerick he found the accommodation for the patients " such as we should not appropriate for our dog kennels ". The usual mode of restraint consisted of passing the patients' hands " under their knees, fastening them with manacles, securing their ankles with bolts, passing a chain over all and, lastly, attaching them firmly to the bed". In that state, he assured the Committee, they had continued for years and the result had been that they had so far lost the use of their limbs, that they were utterly incapable of rising. The Commissioners for Lunacy in England and Wales, referring to the " enormities " existing in public as well as in private asylums prior to 1827, stated that they comprised " almost every species of cruelty, insult and neglect to which helpless and friendless people can be exposed when abandoned to the charge of ignorant, idle and ferocious keepers acting without conscience or control".

Change of Attitude

12. Gradually a more humane attitude towards the mentally ill developed in Western Europe. In 1792, a French physician, Pinel, liberated a number of the insane inmates of a hospital in Paris from chains, which had been worn by some for over 30 years. Even the

pessimists had to agree that these patients became less, rather than more, violent. About the same time, reforms were initiated in England by Tuke, and under his direction the Retreat at York achieved world fame as an asylum which had no bars or gratings and which was conducted on the principle that the utmost practicable degree of gentleness, tenderness and attention to the comfort and feelings of the patients was due to them as human beings and was infinitely the most promising means of effecting their recovery. At the Retreat the use of chains was abolished and therapy in the form of work and exercise and the cultivation of a moral atmosphere was developed. The witness who gave evidence to the Select Committee in 1817 regarding conditions in Clonmel and Limerick also gave evidence regarding an asylum at Cork. He stated that the asylum there was the best conducted he had ever seen or heard of, notwithstanding all the advantages of the Retreat at York. The Physician to Cork Lunatic Asylum at that time was Dr. Hallaran who wrote the first Irish publication on mental illness—" Practical Observations on the Cause and Cure of Insanity". This was published in 1810 and was reprinted in revised form in 1818. It is probably a good indication of what was then enlightened thought in regard to the mentally ill. Among the causes of insanity are mentioned terror of the rebellion (the rebellion of 1798), jealousy, pride, grief, fever, epilepsy, religious zeal, loss of property, excess in drinking, disappointment, lues venerea, consumption, injury to the head and palsy. Among the possible cures are mentioned bleeding, emetics, blisters, purgatives, the use of digitalis, opium, camphor and mercury, warm and cold baths and shower baths and a circulating swing. The circulating swing was invented by a Dr. Darwin and first applied by a Dr. Cox as " a moral and medical mean " in cases of insanity. The swing used by Dr. Hallaran was claimed to be an improvement on that used by Dr. Cox. It was operated by a windlass and could be revolved at the rate of a hundred times a minute, but could be regulated to any lesser rate desired. In some cases it was used in a gentle, steady manner to produce sleep; in other cases it was used with great velocity to subdue mania when other forms of treatment had failed. While many of Dr. Hallaran's beliefs and methods of treatment would not be accepted to-day, his book shows a deep study of the problem, and his emphasis on the need for individual treatment, on the fact that mental illness could be cured or alleviated, that individual discussions with patients were of great benefit, and that occupation was very desirable, particularly in the convalescent stage, is as apposite to-day as it was 150 years ago.

Concepts of Pinel and Others

13. The pioneer work of Pinel, Tuke and other enlightened men led, in some asylums, to a considerable degree of hope for the mentally ill. They came to be regarded as normal people who had lost their reason as a result of exposure to severe stresses. These stresses were called, in the language of the times, the " moral" causes

of insanity, and "moral" treatment was aimed at relieving the patient by friendly association, discussion of his difficulties, and the daily pursuit of purposeful activity. Emphasis was placed on treatment and care, not on custody. "Moral" treatment flourished around the middle of the nineteenth century and, where practised, led to results which, for that period, were exceedingly good.

Decline of "Moral" Treatment

14. The use of "moral" treatment declined during the latter half of the nineteenth century and it probably reached its lowest level during the end of the last and the beginning of the present century. Why this should have happened is not clear. One of the causes suggested was the tendency to build very large hospitals, which made it impossible for the physician to keep in touch with his patients and necessitated their being left, to a large extent, to what was then untrained staff. Others have attributed the change to the growing materialism of the time, the increase in urbanisation and the influence of Virchow, whose teaching that insanity was inherited and due to irreversible cellular changes which could be demonstrated under the microscope was widely accepted. Another cause suggested was the emphasis in legislation on the freedom of the individual. So much trouble was taken to safeguard the interests of the sane, that it was nearly impossible to admit a mentally ill person to an asylum until his disease was very far advanced indeed. Whatever the cause, there is little doubt that "moral" treatment was replaced, to a large extent, by "isolation and safe custody" of the mentally ill. Isolated, they did not obtrude on the public conscience. Safe custody was regarded as desirable so that patients could not harm themselves or others. It was acceptable to untrained attendants as it was much easier to herd and guard patients than to provide them with treatment; it was acceptable to the general public as it was far cheaper than the provision of active treatment. While there was a quota of good and enlightened psychiatrists—indeed some of the greatest thinkers in the field of psychiatry flourished around the turn of the century—frequently the person who was regarded as the best medical superintendent was he who ran his hospital most cheaply and who ensured that those under his care were so carefully guarded that none escaped.

Further Change in Attitude

15. Gradually, however, a change in attitude again occurred. The first major change probably followed the discovery, in 1917, of malaria therapy for general paralysis of the insane, a prevalent and debilitating form of mental illness which affected an appreciable number of all patients admitted to asylums. The fact that it was possible to treat with success a large number of seriously ill patients renewed interest in positive treatment. Several countries made provision for the voluntary admission of patients, an acknowledgment that mental hospitals were places of treatment—and not merely places in which to segregate the mentally ill. The discovery of insulin

treatment in 1933 and electro-convulsive therapy in 1937 further maintained the impetus. A major revolution was caused by the need to deal with problems arising during and immediately after the second World War. The workers concerned with mental illness—psychiatrists, general physicians, clinical psychologists, social workers, nurses and ancillary personnel—had been confined before this, to a large extent, within the narrow limits of their particular fields. The many problems associated with mental breakdown under the stress of war, the selection and training of personnel, the maintenance of individual and group morale, the care of displaced persons and refugees, etc., brought the various workers together, encouraged the development of a team approach, and led to a massive assault on mental illness on a wide front. Contact between nations grew steadily and interest in cultural differences developed. In 1948, the World Federation for Mental Health was formed and, in 1949, a Mental Health Section was added to the World Health Organisation which had been established in 1948. Still further emphasis was added to active treatment by the introduction of the tranquillising drugs in 1954. Since then, other drugs are being added continually to the therapeutic equipment of the physician. These drugs have greatly facilitated the early discharge of patients, and many who formerly could have been treated only as in-patients are now treated in the community. The position arrived at to-day is unique in the history of psychiatry. Modern treatments frequently reduce the duration of the illness and a good measure of social recovery can be achieved in many cases where complete cure is not possible. An era of considerable hope has arrived. Old ideas are being discarded or challenged. Doctors, nurses and public alike display a greater interest than ever before. Mental health has taken a leading part on the world stage. Emphasis has changed completely from custody to treatment.

Emphasis on Community Services

16. In the past, care for the mentally ill was based almost entirely on the mental hospital. There is now, in many countries, a definte trend away from the hospital. In-patient care remains a vital part of the services and, in many areas, the hospital continues to be the natural focus of psychiatric care. However, there is a marked tendency to regard in-patient treatment not as the first and main line of defence but rather as one of many lines of defence embracing various forms of hospital and community care. Permanent hospitalisation is resorted to only when all other measures have failed, and even then the modern approach is to maintain active treatment, together with sustained attempts at rehabilitation, over a long period. Resources are concentrated to a greater extent on preventive services and on the preventive aspects of treatment services. The aim is to enable the patient to maintain himself, as far as possible, in his natural environment in the community, or, if he has to enter hospital, to discharge him as soon as his condition permits. Discharge from

hospital is not, of course, an end in itself. Efforts are made to educate the public to adopt a more liberal and enlightened attitude towards mental illness. More facilities are provided for early diagnosis, advice, and treatment in the community through clinic, out-patient and domiciliary services. The growth of rehabilitation services and of after-care services for persons who have been discharged from hospital is encouraged. Day hospitals are provided in which patients are treated during the day, returning at night to their own homes. Night hospitals are organised for patients who work during the day, but who can be provided with necessary care and treatment by night.

The extent to which services in Ireland should be developed to keep pace with these trends is discussed in Part III.

Expansion of Scope of Psychiatry

17. In most of the asylums which were provided on a large scale in the early part of the nineteenth century little, if any, regard was had to the purely medical aspects of care. The Chief Officer or Master was usually a layman, and it was not until the middle of the century that it became the practice to appoint physicians as chief officers. Even then, there was little recognition of the medical aspects of mental illness and treatment was concerned more with the social aspects of the care of patients. The emphasis on custodial care in the latter half of the 19th century operated against the development of the clinical aspects of medical care. Several psychiatrists recognised the need for and urged a closer link with general hospitals and public health services. By then, however, the custodial system was firmly rooted and, for a considerable time, psychiatry developed outside the stream of general medicine, concerning itself primarily with the institutional care of those suffering from the major psychoses.

Towards the end of the last century psychiatry, and public attitudes towards it, were greatly influenced by a development outside the walls of mental hospitals. Sigmund Freud, a Viennese physician, began to interest himself in the treatment of the neuroses—those mental maladies, with protean manifestations, which so often masquerade as physical ill-health. By concentrating on the life story of individual patients, particularly their early environment and relationships with their parents, he found evidence which convinced him that neurotic behaviour patterns began and that personality was determined in childhood. He emphasised particularly the importance of infant sexuality in determining character and personality.

Freud's own personality, as well as his novel imaginative ideas. attracted disciples among the medical profession and aroused the interest of writers, artists, philosophers and the intelligentsia generally. His controversial concepts became so widely known that general interest was aroused in human motivation and the influence of emotions in ordinary life, so much so that the whole question of mental health became a topic for interested speculation by the layman.

Within the specialty of psychiatry, Freud's teaching inaugurated a

dynamic approach to mental illness. The term psychoanalysis is used to describe his technique for treating individual patients, but it also refers to his theories about the development of human personality and the causation of mental illness. Freud's theories, even though not generally accepted in their entirety, have profoundly influenced succeeding generations of psychiatrists, giving them increased self-knowledge and a deeper insight into their patients' symptomatology and a better understanding of their needs.

To Freud's personality and original thinking must go the credit for a new era in psychiatry, though his views were simplified and modified by his followers. Some who differed from him have made important contributions to present-day thinking, notably Jung, whose views appealed especially to philosophers, and Adler, who stressed the importance of present environment, as oppposed to early influences as a cause of mental ill-health. Adler might be described as the father of social psychiatry, now an important study in our present rapidly changing society.

Integration of Psychiatry and General Medicine

18. Realisation of the need to integrate psychiatry and general medicine has been reawakened by the expansion of the scope of psychiatry and by increased knowledge of the close links between physical and mental illness. Successful treatment of the ill requires a combination of specialist skills, and in such a combination it is essential that the skills of psychiatry should be joined with those of general medicine. Nowadays it is accepted that the medical and nursing professions as a whole should be imbued with a greater appreciation and understanding of the psychological aspects of illness : similarly the psychiatrist should have a greater appreciation and understanding of the physical aspects of illness.

Reduction in the Number of In-patients

19. The discovery of new and improved methods of treating psychiatric illness, with the concomitant change of emphasis from custody to treatment, has led to considerable optimism that there will be a substantial reduction in the numbers for whom residential care will be required in the future. The position is best illustrated in England and Wales where, following an almost continuous rise over a long period, the increase in the number of mental hospital patients ceased and then, in 1955, there began a small but steady reduction which has continued up to the present. Two statistical exercises[1] were undertaken in an effort to assess the number of beds which will be required by psychiatric patients in England and Wales. The first examined the rate of elimination of the existing chronic population in mental hospitals by discharge and death. The second was a study of new admissions, including re-admissions, in

[1] Trends in the Mental Hospital Population and their effect on Future Planning. G. C. Tooth, M.D. and Eileen Brooke, M.Sc., Lancet 1961 i 710-713.

the years 1954, 1955 and 1956. It was estimated that for mental hospital admissions in 1956 the immediate in-patient needs of those who sought psychiatric attention in England and Wales were met by the use of about 870 beds per million of the population—340 short-stay and 530 medium-stay. The first exercise showed that the existing chronic population was running down at a rate which, if continued, would eliminate it in about 16 years. At the same time it was being replaced by a population whose long-stay needs would build up to about 890 beds per million of the population, giving an overall figure of about 1,800 beds per million for all types of care. This is the bed-figure which has been suggested by the British Ministry of Health in its Hospital Building Plan. Apart from the original exercises, a continuous study is being made of the pattern of mental illness, of the admission and discharge rate, of the build up of long-stay patients, etc. The conclusions reached as a result of the original exercises have been subjected to severe criticisms —they have been attacked on many grounds, and it has been contended that the estimates of future bed-needs are Utopian and unrealistic. However, it is understood the current study indicates that, so far, the rate of reduction in the in-patient population continues exactly as predicted. There are now some who contend that the number of beds set out in the Hospital Plan will not be required. Others, however, maintain that the practice of discharging patients to community care has not been established sufficiently long to predict their long-term fate. They suggest that it may well emerge that the " run-down " of hospitals by earlier discharges will be offset by more frequent re-admission of patients who have been in the community for some time. (The Commission accepts that the relapse rate will certainly be high unless adequate community support is provided.) In America a drop similar to that in Britain also occurred, starting about the same time. A recent American Commission[2] did not mention specific bed requirements but, following its report, President Kennedy,[3] in a message to Congress, suggested a new programme for mental health care and stated that, if a broad new mental programme were launched now, it would be possible within a decade or two to reduce the number of patients "under custodial care" by 50 per cent or more. (There are at present approximately 3.23 mental hospital beds per 1,000 of the population in America.) A recent Danish Commission[4] regarded as uncertain the number of beds which would be required in the future, but it worked on the basis of 2.5 beds per 1,000 of the population as a minimum requirement. In this country a drop in the population of mental hospitals commenced in 1959 and has continued up to the present, but the number of beds per 1.000 of the population is still exceptionally high—on 31st December,

•Joint Commission on Mental Illness and Health, December 31st, 1960.

"Message from the President of the United States relative to Mental Illness and Mental Retardation—February 5th. 1963

•Commission to consider the State Mental Health Service in Denmark, March 1952—December, 1956.

1965, the figure stood at *6.6* per 1,000, i.e. based on the number of patients on the Registers of the hospitals on that date.

Appreciation of Need for Improved Services

20. In all countries, the amount of money and effort heretofore expended on mental illness has been completely disproportionate to its impact on the community, on the family and on individuals. In many countries beds for the mentally ill approach 40 per cent of the total number of hospital beds. Some authorities estimate that about one of every three people seeking medical treatment at general practitioner level presents some psychiatric features and that about one person in twelve is likely to need in-patient psychiatric treatment at some stage in his life. Despite these clear indications that mental illness is one of the greatest single problems in the field of health, it has, in many instances, formed a minor part of undergraduate and post-graduate education ; the recruitment and training of doctors and of other specialised staff has not been given adequate attention ; research has been neglected ; the fund of knowledge built up regarding the causes of mental illness, the possibility of prevention, and the efficiency of different forms of care and treatment is, in all countries, disproportionate to the importance of the subject. More and more countries are coming to appreciate that there is a great need for a vast improvement in their services for the mentally ill, for more and better trained staff and for a far greater concentration of effort on the prevention and treatment of mental illness.

PART II

PSYCHIATRIC SERVICES IN IRELAND

CHAPTER 3

PATTERN OF EXISTING SERVICES

General

21. Subsequent Chapters of this report contain detailed comment on the psychiatric services in Ireland. This Chapter gives a broad outline of the existing services. Its purpose is to provide a background against which detailed discussion in subsequent Chapters can be brought into perspective.

Services by Health Authorities

22. At present the major portion of services for the mentally ill is provided by health authorities. The country is divided into 18 mental hospital districts (a new district will be provided shortly in County Wicklow), in each of which there is a district mental hospital. In addition to the district mental hospitals there are four branch or auxiliary mental hospitals. A mental hospital district may comprise one or more administrative counties or one or more administrative counties and a county borough. In districts comprising a single county, the county council, as health authority, administers the mental health services. In other districts, services are administered by a Joint Board consisting of members of the council of each county and of the Corporation of the County Borough, if any, included in the district. These health authorities are obliged to provide services in respect of mental illness for all persons resident in their districts who are unable to pay the full cost of obtaining such treatment—services are provided free, or at a cost not exceeding 10/- per day. Health authorities may also provide services for other persons at an agreed charge. In the year ended 31st March, 1965, the average number of patients resident in district, branch and auxiliary mental hospitals was 17,949. In addition to providing residential treatment, mental hospital authorities provide clinic and out-patient services (see paragraph 24). Health authorities also contribute to the cost of services provided by other bodies (see paragraphs 26 and 29). At Appendix E is a statement giving the names of all health authorities which administer mental hospitals, and indicating the number of beds available and the area and population served.

Accommodation and Facilities in District Mental Hospitals

23. During the course of the enquiry the Commission, or members of the Commission, visited all the district, branch and auxiliary mental hospitals in the country. Some buildings are new, or comparatively new, but most were erected between 1820 and 1900 and are clearly a legacy of the days when the emphasis was on security measures and on custodial care. In many cases praiseworthy efforts

have been made to improve old buildings and some have been brought up to a good, or reasonably good, standard ; others have been sadly neglected. **In the Commission's view a large number are unsuitable in design and lack the facilities necessary for the proper treatment of patients.**

More detailed comments on district mental hospitals are given in paragraph 67.

Out-patient Services

24. In recent years there has been a considerable increase in the out-patient clinic services provided by district mental hospitals. Significantly, this increase coincided with a decrease in the number of patients receiving residential treatment. Details of clinic services provided in 1965 are set out in Appendix G. The following table illustrates the growth of these services and the corresponding reduction in mental hospital populations over the last decade.

Year ending	Clinics		Patients on the registers of District Mental Hospitals (31st December)
	Attendances by Patients	Number of Patients Attending	
31st Dec. 1956 ..	7,386	2,816	20,063
,, 1957 ..	8,735	3,491	19,808
,, 1958 ..	9,674	4,463	20,046
,, 1959 ..	14,264	5,442	19,590
,, 1960 ..	22,393	6,174	19,442
,, 1961 ..	30,589	9,469	19,077
,, 1962 ..	43,235	13,340	18,643
,, 1963 ..	Not available	Not available	18,249
31st Mar. 1964 ..	65,327	22,520	17,935
,, 1965 ..	83,769	25,417	17,694

The development of clinic facilities, while widespread, is not uniform in all district mental hospital areas. In aTeas where there has been least development of clinics, there has been least success in reducing the number of patients receiving residential treatment.

Most hospitals provide domiciliary consultations on request but, in general, the number of such consultations is very small. Apart from one day hospital in Dundalk, Co. Louth, day hospitals and night hospitals, which are a growing feature of community services in other countries, have not yet been established in Ireland.

Health Authority Staff

25. At Appendix F is a statement showing, in broad outline, the main staff in district mental hospitals concerned directly with the caTe and treatment of the mentally ill (administrative and clerical staff, maintenance staff, etc. are not included). The ratio of senior medical staff to patients is approximately 1 to 280; the ratio of all medical staff (other than house physicians) to patients is approximately 1 to

135. **In general, the Commission is satisfied that the number of psychiatrists, of other medical staff, ot psychologists and of certain other para-medical staff is most inadequate** (see Chapter 8).

Services by Private Mental Hospitals and Homes

26. In addition to the district mental hospitals, there are 13 private mental hospitals or homes, containing in all 1,240 beds. The largest of these hospitals is St. Patrick's, Dublin which, as has been stated in paragraph 7, was founded in 1745. Most of the remainder, like the district mental hospitals, were provided during the last century. During the present century only four new hospitals or homes have been opened. Only two hospitals, St. Patrick's and St. John of God Psychiatric Hospital, both in Dublin, provide an out-patient service. Appendix H gives particulars of all the private mental hospitals and homes. It will be noted that they vary considerably in size and in their turn-over of patients.

Accommodation and Facilities in Private Mental Hospitals and Homes

27. The Commission, or members of the Commission, also visited all the private mental hospitals and homes. As has been said already, most of them date from the last century. In general the standard of accommodation and facilities is superior to that in district mental hospitals; in some cases it is very good; in others it can be regarded as adequate for the role which the hospital or home fulfils. Some have the full facilities of a psychiatric hospital, but others provide limited facilities and deal with selected types of patients only. The Commission's views regarding the future role of private mental hospitals and homes are contained in paragraphs 68-71.

Staff in Private Mental Hospitals and Homes

28. At Appendix J is a statement showing, in broad outline, the main staff in private mental hospitals and homes concerned directly with the care and treatment of mentally ill patients. It will be seen that the staff available appears in many cases to be very inadequate. The recommendations contained in Chapter 4 regarding the need for adequate and well trained staff apply to private mental hospitals and homes, but it must be borne in mind that many of these places do not fill the role of psychiatric hospitals and do not purport to provide more than limited services for particular classes.

Services by Voluntary Hospitals

29. In addition to mental hospitals and homes referred to in the preceding paragraphs, a limited number of voluntary hospitals, mostly general hospitals, provide psychiatric out-patient clinics. Health

authorities make payments in respect of persons who attend these clinics and are eligible to receive services free or at a reduced cost from the health authority.

Numbers of In-patients

30. In Ireland, there were 21,075 patients on the registers of mental hospitals and homes at the end of 1958, representing 7.38 beds per 1,000 of the population. A reduction in the number of in-patients commenced in 1959. In 1965 the number was 18,642 representing 6.6 per 1,000 of the population. The following figures, abstracted from the Annual Epidemiological and Vital Statistics published by W.H.O. in 1964, show the comparative position in a number of countries for the year 1961 (or the year nearest 1961 for which statistics were available).

Hospital beds per 1,000 *population in different areas* (1961 *or nearest available year)*

Country	Total number of hospital beds per 1,000 population	Number of psychiatric beds per 1,000 population
Ireland*	21·4	7·3
Northern Ireland ..	11·9	4·5
England and Wales ..	10·4	4·6
Scotland	12·3	4·3
France	13·4	2·1
West Germany† ..	10·6	1·7
Spain	4·4	1·1
Portugal	5·3	·9
Italy	9·3	2·2
Netherlands	7·6	2·3
Denmark‡	10·0	2·2
Belgium	8·0	3·1
Norway	10·6	2·9
Sweden	15·9	4·8
Finland	9·2	3·6
U.S.A.	9·1	4·3
New Zealand	11·6	3·5
Canada	11·1	3·9
Australia	11·0	3·1
U.S.S.R.	8·5	·8
Japan	9·5	1·1

*Excluding Northern Ireland.
†Including West Berlin.
‡Including Faroe Islands.

Statistics in respect of different countries may not be directly comparable, but, even if allowance is made for this, the number of in-patients in Ireland seems to be extremely high—it appears to be the highest in the world. It is hard to explain this. There are indications that mental illness may be more prevalent in Ireland than in other countries; however, there are many factors involved, and in the absence of more detailed research, the evidence to this effect cannot be said to be conclusive. Special demographic features, such as the high emigration rate, the low marriage rate and problems of employ-

ment, may be relevant to the unusually high rate of hospitalisation. In a largely rural country with few large centres of population, social and geographic isolations may affect both the mental health of individuals and the effectiveness of the mental health services. The public attitude towards mental illness may not be helpful to the discharge of patients and their reintegration in the community. On all these points, the Commission could do little more than ask questions. To provide answers would demand years of scientific inquiry for which neither the personnel of the Commission nor the time at its disposal would have been adequate. The Commission considers that a greatly expanded programme of research into these social and epidemiological problems is urgently necessary. Further views and recommendations on this matter are contained in Chapter 7.

PART III

RECOMMENDATIONS FOR THE IMPROVEMENT AND EXPANSION OF PSYCHIATRIC SERVICES

CHAPTER 4

IN-PATIENT CARE

General

31. The Commission decided that in-patient care could best be considered under the headlines of (a) the provision of short-term care by health authorities, (b) the provision of long-term care by health authorities, and (c) the role of private mental hospitals and homes. The Commission is of opinion that, in general, a different approach and different forms of treatment are required by short-term and long-term patients. Patients' needs, however, vary to a considerable extent and frequently it may be found that the treatment of individual long-stay patients can best be provided in short-stay centres. The converse may equally well be true. Consequently, the Commission's proposals in the following paragraphs must be interpreted in a flexible manner.

(a) SHORT-TERM CARE

Concept of Short-term Psychiatric Units in, or associated with, General Hospitals

32. The expansion of the scope of psychiatry, the emphasis on active and early treatment of mental illness and the appreciation of the need to integrate psychiatry and general medicine have led to the concept of psychiatric units in, or associated with, general hospitals. This concept is reflected in the reports of a number of expert bodies which studied the subject in recent times. A Commission on the Mental Health Services in Denmark* recommended that a fundamental principle for future development should be a close union between the psychiatric hospitals and the general hospitals. The British Ministry of Health in "A Hospital Plan for England and Wales (1962)" referred to the increasing need to bring together a wide range of facilities required for diagnosis and treatment and suggested the provision of new district general hospitals which would contain short-stay psychiatric units as well as facilities for all other specialities. The Plan also provides for the addition of psychiatric units to a number of existing general hospitals. In " Action for Mental Health ", an American Joint Commission on Mental Illness and Health (1961) stated: "No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalisation and therefore provides a psychiatric unit or psychiatric beds. Every community general hospi-

•Commission to consider the State Mental Health Service in Denmark, March, 1952—December, 1956.

tal of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region. It is the consensus of the Mental Health Study that definitive care for patients with major mental illness should be given, if possible, or for as long as possible, in a psychiatric unit of a general hospital and then, on a longer term basis, in a specialised mental hospital organised as an intensive psychiatric treatment centre ".

Methods of Providing Short-term Psychiatric Units in, or associated with, General Hospitals

33. While it is generally accepted that psychiatric services and general hospital services should be closely associated, there are different views as to how this should be done. The Danish Commission recommended the provision of small psychiatric hospitals, where possible close to, or as parts of, general hospitals. It considered whether it would be desirable to move the centre of gravity of the psychiatric services to the general hospitals by providing them with psychiatric units which would cater for acute cases. It rejected this idea as it feared that the units would attract too large a part of the limited psychiatric staff away from the treatment of the psychoses, which were regarded as the form of mental illness most in need of attention. The Danish Commission also feared that there would be an unfortunate tendency to concentrate the most effective and varied psychiatric therapies in the psychiatric units, while the mental hospitals might degenerate into purely secondary hospitals. The American Commission visualised the provision of psychiatric units or beds at all large general hospitals, but it also visualised small State mental hospitals where intensive treatment would be given, on a more long-term basis, to patients for whom treatment could not be provided in a general hospital. The Hospital Plan for England and Wales (1962) visualised the large scale provision of psychiatric units attached to general hospitals.

Form of Short-term Psychiatric Units in, or associated with, General Hospitals

34. Short-term psychiatric units in, or associated with, general hospitals have been provided already in this and other countries and more are planned. A uniform pattern has not yet emerged, however. The units can be provided in a variety of ways but, broadly, they fall into three main categories :—

(i) **Comprehensive Units.** These units accept the full range of psychiatric patients, organise out-patient, domiciliary and after-care services and, in general, provide a full service for a specified area for all patients requiring short-term psychiatric care. They are usually closely linked with a long-stay unit in a mental hospital to which patients requiring care for an indefinite time can be transferred.

While they operate in close liaison, and share staff, with a general hospital, they are largely autonomous and their regimen is different from that of the rest of the general hospital.

(ii) **Ward Units.** These are usually small units—possibly containing no more than a few beds which are closely integrated into the hospital setting and frequently have the same regimen. They do not provide a full service for any area and they do not receive the difficult, or the more severely ill, patients.

(iii) **Selective Units.** These units fall between categories (i) and (ii). They are usually small, but autonomous, and are not subject to the same regimen as the rest of the hospital. They do not provide a service for any area and they reserve the right to accept only such patients as they regard as suitable for the unit. They may, or may not, be associated with a long-stay unit.

Arguments for Short-term Psychiatric Units in, or associated with, General Hospitals

35. The concept of the short-term psychiatric unit in, or associated with, a general hospital is relatively new and is still the subject of controversy. The main arguments put forward by those who support the concept are as follows :—

(a) No valid reason exists for the present dichotomy in the treatment of the mentally ill and the physically ill. The successful treatment of both classes requires the skills of psychiatry and general medicine. The present dichotomy tends to deny the best service to both classes of patients; alternatively, it involves duplication of services and facilities. The natural division in the treatment of the mentally ill is between short-term and long-term patients—a division which already exists in many places in regard to physical illness. As in the case of physical illness, the services and facilities required by short-term psychiatric patients differ radically from those required by long-term patients and can be provided readily in a separate centre without any duplication of effort.

(b) All doctors should be aware of the close association between physical and mental illness. Training, both at undergraduate and at post-graduate level, is greatly improved if psychiatric and general medical services are integrated. Similarly, integration improves the training of nursing and other para-medical staff.

(c) A high proportion of psychiatric conditions can be treated quickly and effectively and hospital treatment is frequently of short duration. The emphasis must be on active treat-

ment, however, and it is necessary to create in the hospital an atmosphere in which the whole organisation and environment is directed to the task of returning the patient to the community with the least possible delay. It is difficult to create this atmosphere in the large mental hospital where numbers of long-stay patients are maintained.

(d) Formerly, mental illness was shrouded in fear and mystery. The tendency was to isolate the mental patient behind high walls so that neither his illness nor its treatment would impinge on the public conscience. This aversion from mental illness and the collective resistance to meeting its challenge openly are gradually disappearing, but they have not yet been rejected entirely by the general public. Complete rejection of these outmoded attitudes would be achieved more easily if the mentally ill and the physically ill were treated in the same setting.

(e) Psychiatric patients who require residential treatment should receive it as early as possible. Patients tend to accept treatment much more readily and at a much earlier stage in a short-term, active-treatment unit than in a unit which also caters for long-stay patients and in which new patients often fear that they may become chronic. In addition, patients have a right to privacy. Many do not wish the nature of their illness to be known, whether it be physical or mental, and they object to entering a hospital which automatically indicates the nature of their illness.

Arguments against Short-term Psychiatric Units in, or associated with, General Hospitals

36. The main objections put forward by those who are opposed to the concept of short-term psychiatric units in, or associated with, general hospitals are:—

(a) In general hospitals, psychiatric patients are required to conform to the pattern of care which obtains for the physically ill and nurses in the units are expected to engage in activities which are proper to general nursing. Patients are confined to bed and treated as if they were dependent on assistance from the hospital staff for all their needs. They are seldom encouraged to think or act for themselves. The application of the regimen for physically ill patients would be positively harmful to phychiatric patients whose needs are different from those of the physically ill. Physical rest cannot heal a sick mind and it plays little, if any, part in treatment. Patients should be encouraged to get out of bed, to use initiative, to accept responsibility, to engage in occupational therapy and in various social activities.

(b) The short-term psychiatric unit in, or associated with, the

general hospital deals only with patients with mild symptoms and a good prognosis. It tends to take the easier psychiatric problems and leaves the mental hospital to cope with severely disturbed patients and those with a bad prognosis. This could lead to a loss of status for the mental hospitals which, in time, could come to be regarded as " dumps " for chronic patients.

(c) It is seldom feasible to provide in a general hospital the facilities required for psychiatric patients, such as adequate space for occupational therapy and for indoor and outdoor recreation.

(d) The short-term psychiatric unit would be so much more attractive to many psychiatrists that, with the scarcity of skilled personnel which exists in most countries, the mental hospital would be unable to obtain suitable staff. Thus, some kinds of mental illness which require long-term care, such as the psychoses, would come to be neglected.

(e) The psychiatrist would have little chance of influencing policy in a hospital where he is only one of a large number of specialists, the outlook of the majority of whom might be different from his.

Commission's Conclusions

37. After careful consideration of the relevant factors, the Commission decided that, in principle, the needs of short-term patients can best be met by psychiatric **units in, or associated with, general hospitals. It was satisfied that the advantages of such units, as detailed in paragraph 35, are so great that they would benefit the health services as a whole as well as short-term psychiatric patients. In particular, the Commission is convinced that there is a great need to integrate psychiatry with general medicine and that it is only by such integration that the best services will be provided for the mentally ill and for the physically ill.**

However, the mere placing of psychiatric beds in, or adjacent to, a general hospital will not automatically result in the best, or even in a desirable form of, psychiatric care. It is essential to ensure that the objections referred to in paragraph 36, in so far as they may be valid, are avoided or overcome. The short-term psychiatric units which the Commission has in mind must have a number of essential characteristics—these are detailed in paragraphs 38-42. The Commission is satisfied that the objections referred to at (a) to (d) of paragraph 36 will not be applicable to units possessing those characteristics. The objection referred to at (e) will not arise to a great extent in the case of an autonomous self-contained unit and the Commission is of the opinion that a psychiatric unit will fare better if general hospital standards are applied to it than did the mental hospital when separate standards were applied—invariably to the detriment of the mental hospital.

Need for Integration

38. A short-term .psychiatric unit is only one of many defences against mental illness. These include the creation of an enlightened attitude among the public towards mental illness, the provision of facilities for early diagnosis, advice and treatment in the community through clinic, out-patient and domiciliary services, rehabilitation services, after-care services for those who have been discharged from hospital and hospital accommodation for those requiring long-term care. These defences are interdependent and consequently **it is essential that the short-term psychiatric unit should be very closely associated with other forms of psychiatric care.** Short-term in-patient care must be viewed as a single step in the provision of a full service and it must form part of a wider service providing various other kinds of care.

Types of Patients

39. The psychiatric unit in, or asociated with, a general hospital may not be the most suitable centre for the treatment of certain special classes (see Chapter 6) and alternative arrangements for their care may have to be made, but otherwise **the unit should cater for all types of mentally ill patients requiring short-term in-patient care, including disturbed patients.** The Commission considers that such comprehensive units are necessary, as it is essential to cater for all types of illness—not merely for selected types. Ward units and selective units can help in the integration of psychiatry and general medicine and they can fill a useful, though limited, role in the treatment of the mentally ill. However, they could cater only for a small proportion of the total number of patients in need of care and the Commission considers that they cannot serve as substitutes for comprehensive units.

Accommodation and Facilities Required

40. To cater for all appropriate classes a unit in, **or associated with, a general hospital must provide the full range of treatments and facilities which are normally provided in a psychiatric hospital.** Mental illness includes a wide variety of types and degrees of disorder and patients vary in age and in the extent to which they are disturbing to others or are unable to care for themselves. Provision for some segregation of patients is, therefore, essential. Most patients can be admitted and treated on the same basis as physically ill patients, but statutory provisions will **be** necessary to cater for some patients in respect of whom powers of compulsory detention are necessary—the legislation required is discussed in Chapter 10. Physical rest plays a very small part in the treatment of the mentally ill and, in addition to bed space, there must be adequate day-room space and facilities for indoor and outdoor recreation. The unit will deal mainly with the reception, investigation and treatment of patients suffering from acute or early mental illness, and the length of stay of most patients

will be less than three months. In paragraphs 52 to 58 the range of activities required in long-stay units are described. All these facilities will not be required at the short-stay unit but provision for recreation and some forms of work will be necessary. Day hospital facilities would also be desirable at such units. As indicated in paragraph 36 (a), the general hospital regimen is not suitable for short-stay psychiatric patients. Consulting and treatment rooms, out-patient facilities and accommodation for visitors will be necessary. Medical and nursing staff must be available at all times. **The Commission considers that, when all these factors are taken into account, a self-contained unit will be required and it will be seldom practicable to provide a properly equipped and properly staffed unit with less than 40 beds, or catering for an area containing less than 50,000 people.** The exact number of beds needed in this country is difficult to estimate. In Britain the standard suggested is .5 beds per 1,000 of the population. Due to the exceptionally high admission rate in this country, it is unlikely that this number will be found adequate—at least until out-patient and domiciliary facilities are well developed. Almost certainly it will be necessary also to provide more beds in proportion to the population in places where the population is scattered over a wide area, than in places where the population is concentrated in a small area. A unit of 44 beds attached to a general hospital has been provided in Waterford. The operation of this unit should give an early indication as to the adequacy of 44 beds for the population served. **Provisionally, the Commission is of opinion that .5** to **1 bed per 1,000 of the population will be found necessary.**

Association of Staff with other forms of Psychiatric care

41. Short-term in-patient care is only one facet of the services for psychiatric patients in any area and frequently only one step in the treatment of the individual patient. It is essential that it should be so regarded by the staff of the short-stay units. It is desirable that they should participate actively in community care, so that, where appropriate, they can see patients before their entry into hospital and on their return to their own homes; it is particularly important that they should be associated with long-term care, so that they can follow the progress of patients transferred to long-stay centres and satisfy themselves that the transfer was in the interests of the patients. It is essential that there should be agreement as to the most suitable forms of care for different patients. This will be achieved most readily if staff interchange between the services providing different forms of care. The short-term unit frequently will be **a** centre for post-graduate and, possibly, undergraduate medical education, and for training nurses and other para-medical personnel. It is essential that education and training should include a study of all types of care. Professional isolation of the staff, resulting from their restriction to one type of care, should be avoided. **In view of these considerations, the Commission recommends that each short-term unit**

should cater for a specific area and should be associated with all forms of psychiatric care for the patients from its area.

Staffing

42. **It is** essential **that the unit should be adequately staffed.** While in-patient care remains (and it will almost certainly remain for **a** long time to come) a vital step in the care of some of the mentally ill, the decision to provide in-patient care should not be lightly taken. There is a growing awareness in most countries that institutional life can be disabling emotionally, physically and socially in its effects. The psychiatric unit, therefore, should be staffed to permit of adequate clinic, out-patient and advisory services so that only those patients who clearly need in-patient treatment are admitted. For those patients who are admitted, adequate staff is required to create the atmosphere referred to in paragraph 35 (c) and to provide rehabilitation and after-care services for patients returned to the community. In addition to psychiatrists, the services of a psychologist and a psychiatric social worker will be required at each unit, together with adequate numbers of nursing and other personnel.

Specialist staff from the general part of the hospital should provide services, as required, in the psychiatric unit and staff from the psychiatric unit should similarly provide services in the general part of the hospital.

Provision of Short-term Psychiatric Units

43. The Commission is satisfied that, where it is feasible, short-term psychiatric units should be provided in or at general hospitals. Circumstances in particular areas must, however, be taken into account—e.g. the provision of new units would not be justified in areas where there are already units suitable for short-term care which can be operated in close association with a general hospital. The Commission did not carry out a detailed study of every area, but from a general study of the position it was satisfied that the problem has to be considered in relation to different sets of circumstances as set out in paragraphs 44-49.

44. It has been decided already to provide short-term psychiatric units in or near general hospitals in four mental hospital districts—Waterford, Tipperary, Mayo and Carlow-Kildare. In Waterford City a separate unit in the County Hospital in Ardkeen has been made available and is now fully operative as a psychiatric unit in a general hospital. A new unit will be completed soon in Clonmel, Co. Tipperary. This is located beside a general hospital and can be operated in conjunction with it. A new unit is being provided also in Castlebar, Co. Mayo. Owing to the absence of a suitable site, it was impossible to build this unit at the County Hospital. However, it will be reasonably close to it and undue difficulty should not be experienced in operating **the** unit in association with the general hospital. The existing mental hospital in Carlow serves two counties.

Carlow and Kildare, and it has been decided to provide a psychiatric unit for Kildare in the grounds of the County Hospital at Naas.

45. There are four mental hospitals in which it is reasonably clear that suitable accommodation for short-term patients could not be provided by adapting existing buildings—Castlerea, Enniscorthy, Kilkenny and Killarney. The Commission is satisfied that new units are required in the areas served by these hospitals. **The Commission recommends that the units should be provided in, or** at, **the County Hospitals in Roscommon, Wexford, Kilkenny and Tralee.**

There is a regional general hospital in Limerick. The Commission considers it very desirable that there should be a psychiatric unit in, or operated in close association with, this hospital, in view of the important role it fills in the area. There is a small short-stay unit at the mental hospital, but the Commission does not regard **it** as adequate. **It recommends that a new unit should be provided in, or at, the regional hospital.**

46. Units which are suitable for short-term patients are already available in the mental hospitals in Ennis, Monaghan, Mullingar and Sligo. In each of these instances there is a general hospital within reasonable distance of the mental hospital. The Commission does not consider that the provision of new units in the county hospitals would be justified at present in these areas. **Accordingly, it recommends that the existing units should be operated in close association with the general hospitals.** Similar considerations apply in the case of the mental hospitals at Letterkenny and Portlaoise. Detached short-stay units are not available, but in each case a part of the hospital has been set aside as a short-stay unit. The mental hospitals adjoin general hospitals **and consideration should be given to the possibility of operating the short-stay units in association with the general hospitals. If mis is not found to be feasible new units should be provided.**

A unit for short-term care has been developed recently in the mental hospital in Ardee, Co. Louth. Owing to the small size of this county, and the ease of communication with general hospitals in the area, the Commission considers that it would not be justified in recommending the establishment of a further psychiatric unit at a general hospital. **It suggests that the matter should be reconsidered when experience has been gained of the operation of the unit in Ardee.**

A particular problem arises in the case of County Carlow. **At** present the mental hospital in Carlow town serves two counties, Carlow and Kildare. As mentioned in paragraph 44 it has been agreed already, to provide a psychiatric unit in the grounds of the County Hospital, Naas, to **cater** for County Kildare. For geographical reasons the unit **for** short-term patients from County Carlow should be in Carlow town. However, there is no suitable general hospital in the town and consequently **the Commission has no**

option but to recommend that the short-term psychiatric unit should be provided in, or at, the mental hospital. Here again, every effort should be made to develop close working relations with general hospitals in the region.

47. There is a suitable short-term unit at Ballinasloe. This hospital is situated on the eastern border of Galway County and is badly situated to provide a service for the whole county, parts of which are up to ninety miles from Ballinasloe. The greatest concentration of population (23,000) is in Galway City, forty miles from Ballinasloe. There is a regional general hospital, a teaching hospital, ai Galway. **The Commission is satisfied that a psychiatric unit should be provided at mis hospital to deal with the short-term care of patients from Galway City and from the western part of Galway.** A unit for short-term care will be required also for eastern Galway. The existing unit at Ballinasloe is suitable. There is not a local authority general hospital at Ballinasloe but there is a voluntary general hospital. The Commission suggests that consideration should be given to the possibility of linking this unit with the voluntary hospital.

48. The position in Dublin is particularly complex. There is a unit of 167 beds suitable for short-term care at St. Loman's, Ballyowen, and units containing about 180 beds in St. Brendan's, Grangegorman. Private hospitals, particularly St. Patrick's and St. John of God Psychiatric Hospital, also provide a considerable amount of short-term care. St. Patrick's contains 330 beds of which 200 could be said to form a unit for short-term care. The St. John of God Psychiatric Hospital contains 157 beds of which 80 could be said to form a unit for short-term care. None of the four units mentioned is in, or operated in association with, a general hospital. Clinical psychiatric teaching of medical students is, at present, provided at St. Brendan's and St. Patrick's. There is one large local authority general hospital, St. Kevin's, but it is not recognised as a teaching hospital. There are (apart from special hospitals) ten hospitals recognised as teaching hospitals :—

* Adelaide	160 beds
The Charitable Infirmary, Jervis Street	244 "
* Dr. Steeven's Hospital	203 "
Mater Misericordiae	534 "
* Meath Hospital and County Dublin Infirmary	256 "
* Mercer's Hospital	124 "
* Royal City of Dublin Hospital	193 "
St. Laurence's Hospital	370 "
St. Vincent's	349 „
* Sir Patrick Dun's	167 "

•**These six hospitals form a federation and possibly could be regarded as one unit.**

There are psychiatrists attached to a number of these hospitals. They do out-patient work and, to a small extent, provide in-patient treatment, but there is not a comprehensive psychiatric unit attached to any hospital. Even if the federated hospitals could be regarded as one unit, there still would be five teaching general hospitals, each under the control of a separate independent body. In addition to these hospitals, and to St. Kevin's, there are two general hospitals which are not recognised as teaching hospitals and a number of special hospitals, some of which are classified as teaching hospitals. Even if it were decided to restrict psychiatric units to teaching hospitals it still would be very difficult for these hospitals to provide and operate units possessing the essential characteristics outlined in paragraphs 38-42. In addition, it is almost certain that it would not be possible to provide comprehensive units in most, if not all, of these hospitals—the units would have to be situated away from the general hospital. There is little point in providing new buildings away from the general hospitals, since suitable buildings are already available in the existing mental hospitals. **The Commission accordingly is of opinion that the most satisfactory solution in Dublin is to use the units in the mental hospitals as the main basis of short-term care.** Small units, or beds, catering for selected patients only, probably will continue to be provided in general hospitals. As indicated in paragraph 39, they can fill a useful but limited role. **While the Commission recommends that the units in mental hospitals should be used as the main basis of short-term care, it considers that much closer links than exist at present should exist between the general hospitals and the psychiatric units.** Members of the staff of some of the private hospitals are on the staff of general hospitals, but members of the staff of the health authority hospitals are not on the staff of any of the general hospitals. Members of the staff **of** the general hospitals are not on the staff of the health authority hospitals although arrangements are made to call in a limited number of non-psychiatric specialists on a consultant basis. Health authority clinics are not conducted at any general hospital. Some general hospitals provide out-patient psychiatric clinics and are paid for them by health authorities, but the clinics are not in any way co-ordinated with the health authority clinics and the psychiatrists conducting them are not involved in the subsequent treatment of patients whom they consider should be admitted to health authority hospitals. The overall position is unsatisfactory. **The Commission considers that there should be close liaison between the short-term psychiatric units and the general hospitals, so that they can provide jointly the best service for the mentally ill and the physically ill. Such liaison between a health authority hospital and a voluntary general hospital may present difficulties, as the method of recruitment and remuneration of staff and their conditions of service in the health authority hospitals are different from those in die voluntary general hospitals. These are not, however, insuperable difficulties and with goodwill on both sides, it should be possible to arrange for a limited exchange of staff and joint use of facilities.**

49. The position in Cork is also complex. The district mental hospital (Our Lady's Hospital, Lee Road) caters for the short-term care of patients from Cork City and County (population 330,000). **To** cater for the needs of West Cork, parts of which are situated 80 miles from Cork City, it has been decided already to provide a short-term unit of 40 beds attached to a district hospital at Skibbereen. A vacant building is available for this purpose. While the location of this unit is not ideal, its use is fully justified as an interim measure to meet an acute need in the area. To deal with the remainder of the population (approximately 280,000 people) about 250 short-stay beds will be required. There is at the District Mental Hospital a new and suitable short-stay unit (St. Anne's) containing 60 beds. In addition, it has been decided to convert part of the former sanatorium at Sarsfields Court into a psychiatric hospital. There is a large local authority general hospital (St. Finbarr's) which deals with acute and long-stay patients. This hospital is recognised as a teaching hospital, but it is very old and it has been decided to build a new regional hospital on a site some distance away from St. Finbarr's. In addition to St. Finbarr's, there are five voluntary general hospitals in Cork. Any attempt to provide at general hospitals psychiatric units possessing the essential characteristics outlined in paragraphs 38-42 would give rise to much the same difficulties as would arise in Dublin. **The Commission is of opinion that the most satisfactory solution would be to attach a Psychiatric Unit to the new regional hospital which is to be built. It recommends that a unit of not less than 50 beds should be provided at this hospital. In addition to this unit, it will be necessary to have an additional unit or units containing approximately 240 beds. The Commission considers that the existing Unit at the district mental hospital—St. Anne's—should be retained for this purpose and that, in addition, further units should be provided at this hospital and at Sarsfield's Court As in the case of the Dublin hospitals, these units should be operated in close liaison with general hospitals in the area. A unit should be provided at Bantry County Hospital in lieu of the temporary unit at Skibbereen.**

(b) LONG-TERM CARE

General

50. The various components of a service for the mentally ill are interdependent and a complete and satisfactory service cannot be provided unless all parts are developed adequately. **The Commission considers that it is just as essential to develop facilities for long-term residential treatment as it is to provide short-term psychiatric units.**

Most countries now are placing greater emphasis on active treatment of long-stay patients, and experience to date demonstrates clearly that, with modern methods of treatment, many patients can be restored to the community who, in the past, would have spent all their lives in a mental hospital. Even patients who cannot be restored to the community are enabled to lead fuller and happier lives if

proper facilities are provided. The principle that the first essential of a hospital is that it should not do the patients harm was enunciated over a hundred years ago, but only in recent times has it been fully appreciated that hospital life can be emotionally, physically and socially disabling in its effects, and that the condition of many long-stay hospital patients is, at least in part, a product of their environment and the way they are treated, rather than wholly a result of the illness which caused their admission. It is essential that the long-stay hospital should be developed as a centre for treatment and not merely as a centre for custodial care; its aim must be to rehabilitate and to restore to the community as many patients as possible : for those who cannot be restored to the community, the aim must be to save them from a vegetative existence and to enable them to lead lives as full and happy as their disabilities permit. To fill this role, the long-stay hospital must have the features and facilities detailed in paragraphs 51-65; in particular, it must have the closest association with other psychiatric services in the area and with the general community.

Staffing

51. **The most important requirement for the long-stay unit is an adequate and well trained staff capable and willing to operate the unit as a therapeutic centre where the emphasis is on treatment, not on custody.** A good staff can compensate for many deficiencies in buildings and facilities, but even first class buildings and facilities cannot adequately compensate for deficiencies in the number and quality of staff. The exact staffing depends on the size of the unit and the type of facilities provided, but, at the very minimum, there should be available the services of a senior and a junior psychiatrist, a general physician, a surgeon, a geriatrician, a radiologist, an ophthalmologist, a pathologist, occupational therapists, physiotherapists, social workers, nursing staff and other personnel (such as instructors and placement officers) concerned with the rehabilitation of the patient and his preparation for return to the community. General practitioners from the area should be attached to the hospital as part-time clinical assistants to assist in the psychiatric care as well as the physical welfare of the patients. The active participation of general practitioners would have the desirable effect of integrating general practice with psychiatry, as well as helping to ensure that long-stay units do not degenerate into centres for custodial care.

Activity

52. **Planned and purposeful activity should be an essential feature of every long-stay hospital.** Occupation is particularly needed in **a** long-stay psychiatric hospital to prevent patients from becoming " institutionalised " and from " escaping into illness " and to keep them mentally alert and interested. An expert Committee of **the** World Health Organisation* has stated that planned and purposeful

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activity is one of the most important characteristics of the therapeutic community and that the planning of the patient's day is probably the most important therapeutic task of the psychiatric hospital. **The Commission considers that while the value of activity has long been accepted in principle, enforced idleness is the lot of a large proportion of long-stay patients. There is little doubt that such idleness is one of the major causes of apathy, deserialisation, lack of interest and of initiative, and deterioration in habits and in general personality. All patients, except those prevented by physical illness, should be engaged in some form of suitable activity, and to ensure that this is so is one of the major tasks in a long-stay hospital. It is one of the most important and essential aspects of therapy and constitutes the greater part of the work of nursing and other staff.**

Occupational Therapy

53. In the past the term "occupational therapy" was used to describe the work and recreational activities used in the treatment and rehabilitation of patients. Work activities tended to be mainly concerned with arts and crafts and too often they were limited to an occupational centre or department where a small number of the Datients were engaged in making rugs, baskets, lampshades and similar objects, and in activities like weaving and sewing. Of late, more emphasis has been placed on work which is more closely related to work in the community, and patients are expected to achieve an output and a standard of work comparable to that achieved in normal employment. **It has been realised that a small occupational therapy department, concentrating on pleasant occupation and dealing with only a very limited number of patients, does not provide adequate activity in a psychiatric hospital. While there is undoubtedly a place for the occupational therapy department and for traditional craft work, activity must be provided for patients throughout the whole hospital.** It must be remembered that long-stay hospitals are large, and that the patients vary considerably in age, physical and mental abilities and interests, so that it is necessary to provide a wide range of activities. These activities can take the form of recreation (including the pursuit of hobbies), work of various kinds, training and education.

Recreation

54. Recreation is not something provided merely for the amusement and entertainment of patients!—it is a very important part of their treatment and socialisation. It therefore merits as much attention as other forms of therapy. Reading, radio, television and the cinema all have **a** place but, particularly for patients who are inclined to be passive, a large part of recreation should be devoted to active pursuits. Dances, team games, music, art and drama are all useful in restoring confidence, or in developing an interest in social activities in shy and reserved patients. Group discussions on topics of the day are very useful in keeping the patients in

contact with the outside world. Patients can be grouped to form clubs which provide a very useful medium for stimulating greater social activity. Patients should be encouraged, indeed expected, to assist in the planning and organisation of recreational activities. Hobbies and interests acquired in hospital may continue to be of benefit on return to the community. Organisers of recreation, who may be occupational therapists, are an essential part of the therapeutic team.

Purpose of Work

55. The purpose of work by patients always must be borne in mind. Work is a part of treatment and its purpose is to help the patient towards recovery—to teach him work habits which he may have lost or never have acquired, to assist him to mix socially and co-operate with others, to give him a sense of responsibility or confidence which he may have lost, to correct unusual patterns of behaviour, to restore physical abilities, to create interest, to avoid boredom, and to teach new skills. The restoration of physical abilities can be of particular importance in the long-stay hospital and suitable work, or physical training, should be provided for this purpose. In most cases the aim of work is to fit the patient to resume his place in the community; for those who cannot be restored to the community its aim is to prevent their deterioration to a vegetative existence, to facilitate their care in hospital and to enable them to live as independent and useful lives as their disabilities will permit. In the past, work by patients was too often regarded as a cheap means of having work done on behalf of the hospital. The work available was divided between a large number of patients with the result that few, if any, had to work at a normal rate. Many patients were engaged on monotonous and frequently ineffectual work, such as pushing floor polishers to and fro for very long periods. Work was not therapeutic—it killed good work habits and probably hastened the "institutionalisation" of the patient. Work which is of benefit to the hospital can also be of benefit to the patient and the Commission considers that activities such as making beds, cleaning wards, participating in maintenance and repair work, assisting in kitchens and laundries, or engaging in agricultural work are not necessarily undesirable. All of these can provide a desirable form of occupation for patients—provided that the patients are selected for the work in their own interests, and not in the interests of the hospital, and that the purpose of work by patients is not forgotten. The work which a patient can perform most adequately is not necessarily that most suited to his treatment, at least during all stages of his illness, e.g. typing may not be the most suitable form of therapeutic work for a typist and work on a farm may not be the most suitable form of occupation for a farmer or farm labourer. **In all cases, the form of work to which the patient is assigned should be determined by his medical, social and psychological needs and, if necessary, it should be changed**

as these needs change. The type of work on which patients are engaged must, therefore, be kept under continuous review.

Range of Suitable Work Activity

56. Subject to the condition that patients are selected for work according to their medical, psychological and social needs and in their own interests, a very wide range of work activity can be made available in a long-stay psychiatric hospital. Occupation can be provided for some patients by art and craft work, such as making rugs, baskets and lamp shades, leather-work, knitting and needle-work. This type of activity frequently is suitable for elderly and bedfast patients. For others, work of a heavier type such as wood-working, metal work and ceramics is more suitable. Some can be employed usefully on tasks such as maintaining wards and assisting in kitchens and laundries. Many will derive more benefit from industrial or agricultural or horticultural projects. The exact nature and extent of the work activities which can be developed in individual hospitals must be determined by the needs of the hospital, by its location, by factors such as the availability of industrial work, the facilities for agricultural and horticultural work, and the possibility of obtaining suitable markets. In this connection, the Commission wishes to emphasise that experience has shown that Trade Unions are very co-operative in helping to overcome any difficulties which may arise with local workers when projects of this nature are initiated.

Industrial Therapy

57. In several countries industrial therapy is becoming an important part of the treatment programme, particularly for long-stay patients. The term is used in **a** variety of ways. Some use it to designate any work provided for patients which is of an industrial nature, as opposed to domestic, agricultural or horticultural work or work dealing with arts and crafts. Others use the term only in relation to industrial work which is used as a means of rehabilitating long-stay patients (mainly schizophrenic) by restoring interests, attitudes, standards and work-habits which have been lost through years of illness and institutionalisation. In the first sense, industrial therapy can be regarded in the same way as any other work activity provided in the hospital. It can be a most useful supplement to the range of activities in the hospital and can provide work **for** many whom it would be difficult to employ on other projects. In **the** second sense (i.e. as **a** means of rehabilitating long-stay patients) industrial therapy consists in the organisation of work in **a** manner which resembles, **as** closely as possible, work in competitive conditions in the community. Patients are required to work set hours, to observe punctuality, to co-operate with other workers, to retain concentration, to reach **a** normal output and, in general, to achieve the standards of **a** good worker in outside employment. Industrial therapy in this sense can include agricultural

and horticultural work, but in most places it is confined to factory-type work, particularly assembly-line work, where norms for output are readily determined and measured. In some centres, e.g. the Industrial Rehabilitation Units operated by the Ministry of Labour in Britain, psychiatric patients work with other patients, and this association with non-psychiatric patients is regarded as an essential feature of the rehabilitation process. In other centres, industrial therapy is provided solely for psychiatric patients—sometimes in mental hospitals and sometimes outside mental hospitals. The centres outside mental hospitals may be operated by organisations which are independent but normally have a close link with the mental hospital. In the units in mental hospitals, psychiatric nurses and occupational therapists usually play an important role though persons skilled in industrial work may be employed. There is a considerable amount of medical control and supervision. In units outside hospitals there is a tendency to employ persons skilled in industrial work, rather than nurses or occupational therapists. The unit is frequently seen as a means of completing the industrial therapy already begun in the hospital and an effort is made to provide an environment which more closely resembles that of a normal factory than is possible in a hospital setting. Sometimes hostels are provided in conjunction with industrial therapy units to act as half-way houses between life in the hospital and life in the community.

There is no doubt that industrial therapy is very desirable as an addition to the work activity of long-stay hospitals, and as a means of providing sheltered employment (see paragraph 60). It is impossible to say to what extent it may be practicable to develop it in this country as a specific means of rehabilitating long-stay patients. The country is predominantly rural in character and there is not full employment. There is not the same range of industrial work available as in Britain and, in most areas, there is not a keen demand for industrial workers. If, however, industrial therapy is regarded as including agricultural and horticultural work and is accepted primarily as a means of creating good work-habits, it may still be of considerable benefit in this country. **The Commission recommends that hospitals which consider they can develop industrial therapy projects to rehabilitate long-stay patients should be encouraged to do so. It also recommends the development, on an experimental basis, of one or two units outside mental hospitals. The aim of these units should be to complete, in appropriate cases, the industrial therapy begun in the hospital and to fit patients for work in the community. The units should be operated in very close association with a mental hospital and, where necessary, hostel accommodation should be provided by the hospital.**

Educational Content

58. Frequently, activity in a long-stay psychiatric hospital should have an educational content. Development of new skills, e.g. expert training in domestic work or in industrial, agricultural and horti-

cultural work, will give many patients a better chance of obtaining or retaining employment. For others, the development of new skills will add to their interests or create hobbies and frequently will help to restore their confidence and enable them to engage in activities which they would not undertake otherwise. **Habit training is an important part of education, especially in the case of long-term patients. Snch patients often deteriorate in their personal habits, in the care of their dress and in their table manners. Proper training can mitigate this deterioration and should be available in every hospital.**

Payment for Work

59. The Mental Treatment Act, 1961, authorises payments to patients in respect of work performed by them. The Commission understands that this provision is used only to a limited extent. It has been found that such payments can make a very important contribution to therapy. The ability to earn money and to decide themselves how it should be spent considerably assists the rehabilitation of many long-stay patients. It restores a sense of usefulness and a sense of confidence which may have been lost, and it is **a** useful step towards restoration to the community. **The Commission is satisfied mat it is in the interests of most patients that they should be paid for any work performed by them; it recommends that the present provision be continued and extended.**

Sheltered Employment

60. Although in all cases the aim of residential treatment is to return the patient to the community, it must be accepted that some long-stay patients will require residential care for an extended period —possibly for the remainder of their lives. **Sheltered employment, i.e. employment in which they are not subject to competition from non-handicapped workers, should be organised for as many of these patients as can undertake it.** Mental hospitals already provide an appreciable amount of sheltered employment in agricultural and horticultural work, in domestic and laundry work and, to a limited extent, in industrial work. The total amount provided is, however, very inadequate in most hospitals and work is not properly planned. **The Commission considers that there should be a greater concentration on horticultural and industrial work.** Most hospitals are in county towns where factories are located. Experience indicates that many factories have a certain amount of work which they are willing to give on sub-contract to properly organised sheltered workshops. **In the Commission's view, mere are few hospitals in which a sheltered industrial workshop could not be organised effectively. The employment of an organising officer of the factory manager grade would be justified in many cases. It** would be his function not alone to organise the operations undertaken in the workshop but also to approach the managers of local factories seeking work for patients. Some patients possibly could be dis-

charged to the community, or to hostels, and participate in sheltered employment by attending the hospital workshop daily. In certain areas it may be found that well-organised voluntary agencies would be prepared to organise and operate sheltered workshops outside the hospitals. Sheltered workshops can be run in conjunction with industrial workshops organised for the purpose of rehabilitating patients, but the two types of workshop should be kept separate as their aims and methods of working will be different.

Placement Services

61. The Placement Officer serves as a link between the patient and employment. In addition to ascertaining the jobs available in particular localities and determining their suitability for former patients, he must foster in employers and their staffs a more enlightened attitude towards the employment of such persons. Placement services are operated at present by the National Organisation for Rehabilitation, by the Rehabilitation Institute, Limited, and by some district mental hospitals. **The Commission recommends that every health authority should ensure that placement services are available in its area, either by using the services of voluntary organisations or by organising a service through its own officers. In either event, the placement officers should have completed an appropriate course of training and should be thoroughly familiar with the needs of the mentally ill.**

Physical Environment

62. In the past, in this country as in other countries, many mental hospitals were places where large numbers of the mentally ill were kept in custody and where success was judged not on the turnover of patients, but on the hospital's ability to keep down costs. Expenditure on furniture and furnishings, maintenance, catering, heating and sanitary facilities was minimal, with the result that in many hospitals or parts of hospitals, patients were accommodated under primitive conditions. Often, the excuse was made that mentally ill patients were oblivious of their suroundings and completely unaffected by them. In recent times, it has been found that few, *k* any, patients are oblivious of their surroundings and that, as far as the great majority, if not all, are concerned, the standards of accommodation and facilities with which they are provided have an important bearing on their response to care and treatment in hospital. Another argument used to excuse substandard conditions was that many patients had a poor domestic background and that they felt " more comfortable and at home" in surroundings which approximated to their normal living conditions. This contention has been disproved in many mental hospitals where improvements in living conditions have been followed by marked improvements in the patients' appearance and behaviour. In any event, if this type of argument were accepted it would be desirable to provide in all hospitals, general as well as psychiatric, a variety of environments

ranging from the primitive to the excellent to cater for all the patients likely to be admitted. **The Commission is satisfied that a good environment is essential if the hospital for long-term care is to fill adequately its role as a centre for the treatment and rehabilitation of patients.**

Preservation of the Individuality of the Patient

63. One of the major defects of the large mental hospital was that it tended to destroy the patient's individuality. Patients were organised, to a very large extent, so that they could be looked after easily. They were grouped in masses so that staff could cope with large numbers; they were deprived of all personal possessions so that nobody would have to accept responsibility for the storage, custody and use of personal items; they were discouraged from using any initiative, as it was easier for the staff if all patients acted in the same way; they were generally assumed to be untrustworthy, as this was the safest attitude from the point of view of those in charge; they were kept in close custody, continuously watched, surrounded by bars, closed windows and high walls; they were frequently dressed in uniform clothing; and it was assumed that they were liable to escape, to attack other patients, or to attempt to commit suicide if left alone, even for a few moments. A number of these defects exist to this day in some of the mental hospitals in Ireland. **The Commission considers that the relatively large size of these hospitals is, in part, responsible and recommends that consideration should be given, at an early stage, to the division into smaller separate hospitals of any hospital exceeding 750 beds in size.**

As part of treatment, every effort must be made to preserve the individuality of the patient and to encourage him to accept responsibility and to use initiative. To achieve this end it is essential that the grouping of patients in large masses should be discontinued; that large dormitories and wards should be broken down into small units; that dining should be decentralised, so that patients have their meals in small groups or, alternatively, that large dining rooms should be furnished with small tables, so that patients are served with then-meals as in a hotel or restaurant; that patients should be encouraged to wear their own domes and to retain personal possessions; that any clothing provided by the hospital should be varied in colour and design and of good quality, so that it will not automatically be recognised as institutional clothing; that patients should be assumed to be trustworthy unless there is evidence to the contrary and that, unless very exceptional circumstances exist, restrictions such as locked doors, barred windows and high walls should be avoided; that patients should be given proper forms of address to preserve the dignity of the individual; that men and women should mix freely at recreation and at work and at meals, as they do in normal life; that visitors should be encouraged; and that everything possible should be done *to* sustain the patient's links with, and his interest in, the outside world. The Commission is pleased to record that several

mental hospitals in Ireland have made substantial progress in eliminating many of the features which tended to destroy the individuality of the patient.

Liaison with Short-term Units

64. As indicated in paragraph 41, olose liaison and co-operation between the short-term units and long-term centres for psychiatric patients is essential. Broadly, it is visualised that junior staff, particularly staff in training, should interchange ibetween the two places. The duties of the senior staff may relate mainly to one place, but, by a limited interchange of duties, it should be possible for them to remain in contact with all branches of the work in the two types of centre. **There should be clear overall direction of medical policy to ensure that the short-stay unit and the long-stay unit complement each other as part of a comprehensive service.** The senior medical staff at the short-stay unit, whose duties would mainly relate to the unit and the domiciliary and out-patient services, should be positively associated with the long-stay unit, e.g. by working there for a session or two a week, so that they may follow the progress of patients sent to the long-stay unit. The senior medical staff at the long-stay centre, whose duties would mainly relate to that centre, should do out-patient work and be linked with the early treatment of patients, e.g. by working for a session or two a week in a short-stay unit.

Liaison with the Public

65. All the measures recommended in this Chapter will serve to prevent long-stay hospitals from degenerating into centres of custodial care. The interest of the general public must also be stimulated ; ways and means of achieving this are discussed in paragraphs 176 to 185.

Number of Long-term Patients

66. The Commission is satisfied that, with increased emphasis on community care and on the active treatment and early discharge of patients, there will be a considerable reduction in the number requiring long-term residential care, but that some patients will continue to need long-term care. There is also, in most mental hospitals, a large number of long-term patients, many of them accumulated from the time when methods of treatment were much less effective than they are to-day. Many of these are old or institutionalised, or have lost their place in the community. The rehabilitation of many is still possible but some will remain in mental hospitals and the reduction of the numbers in this group will, of necessity, be a relatively slow process. Even though the number of long-stay patients will be reduced substantially in future years, enough will remain to create a major problem. The number of patients in mental hospitals on the 31st March, 1963, was 19,829. Of these about 2,700 were mentally handicapped. About 4,600 patients were in hospital for 15

months or less. About 2,000 were patients (other than aged persons) for whom special provision on the lines discussed in Chapter 6 will be necessary. The remainder, about 10,000 patients, were in hospital for fifteen months or longer. This figure could be regarded as the approximate number of mentally ill patients at present receiving long-term care. Over the past five years the numbers maintained in district mental hospitals have decreased by 276 patients a year. It is reasonable to expect that this decrease will continue or will accelerate, but no immediate and dramatic improvement can be expected. However, it should be possible to reduce numbers progressively, so that a considerable reduction may be expected in a relatively short time. Until detailed analyses are obtained of statistics which are at present being collected by the Department of Health, and until the effect is seen of the increased and improved services which the Commission recommends, it will be impossible to say with any degree of certainty how many long-term beds will be required in future years. **The Commission suggests, however, that die aim should be to decrease the number of long-stay beds by an average of 300 a year over the next 10 years and by 400 a year over the following five years, so that in 15 years the total number of long-stay beds will be reduced from 10,000 to approximately 5,000. The Commission desires to emphasise that these are target figures only and that the actual need for beds will have to be determined from time to time. Assuming, however, that the target figures are reasonable, the immediate aim should be to have approximately 10,000 long-stay beds of good hospital standard, approximately 5,000 of which can progressively be taken out of use.**

Use of District Mental Hospitals

67. Since the number of beds required for the long-term care of the mentally ill will be considerable, it is desirable that the greatest possible use should be made of existing district mental hospitals, provided that they are, or can be made, suitable. During the course of the inquiry the Commission, or members of the Commission, visited all the district, branch and auxiliary mental hospitals in the country. Some buildings are new, or comparatively new, but most were erected in the last century and many are clearly a legacy from the days when the care of the mentally ill took the form of security and custodial measures. Factors such as economy and the desire to have large groups of patients supervised by a relatively small staff led to the development of barrack-like buildings, characterised by large wards, gloomy corridors, stone stairways, inadequate heating, inadequate sanitary and bathing facilities, and poor furniture and furnishings. In many hospitals, or parts of hospitals, particularly in recent years, considerable efforts have been made to improve standards and to remove the jail-like appearance and the atmosphere of pauperism which previously prevailed. By judicious renovation, and by measures such as the provision of good furniture and furnishings, the improvement of catering facilities, and the division of very large

rooms into a number of small rooms an improved standard of accommodation has been achieved in some hospitals and it has been clearly shown that age alone does not prevent the development of a building so as to provide acceptable accommodation. Unfortunately, the carrying out of improvements has not been uniform and some hospitals, or parts of hospitals, have a standard of accommodation which varies from poor to bad. Some have adequate catering, heating and sanitary arrangements, but most need considerable improvements in regard to these facilities. Furniture and furnishings are inadequate in most cases. Facilities for occupational, recreational and industrial therapy and for proper medical treatment, are poor in most hospitals. In addition, a custodial approach still persists in some hospitals.

The following comments taken from reports by members who visited these hospitals can be accepted as an indication of the general position :

(a) Considerable overcrowding.

(b) Obvious lack of furnishings, particularly in the dormitories.

(c) Care provided was mainly custodial. Little occupational therapy was provided; a large group of male patients was observed walking aimlessly around a recreation ground, with nurses on sentry duty, as it were, at various points.

(d) Sanitary and bathing facilities were generally inadequate and of poor standard—lack of privacy, and seats missing from W.Cs.

(e) Catering was poor—kitchen very bad—cooking equipment bad (cracked enamel etc.)—washing-up facilities poor.

(f) Medical staffing was inadequate—nursing on the male side was poor—occupational therapy was absent on the male side and only very limited facilities were available on the female side. Generally, there was too much bed-nursing of old patients. There were no after-care facilities and no domiciliary visiting. A pharmacist was not employed.

(g) There was no proper library; magazines and newspapers were lacking. There was no canteen—no shop—no beauty parlour or ladies' hairdressing salon—no chiropody service—facilities for dental extractions only, and no conservative dental treatment.

(h) Clothing was generally very poor and institutional looking—bed clothing was inadequate and of poor quality—the laundry was very bad and the laundered articles were of particularly poor standard—male patients were not provided with night attire.

(i) Day-rooms and dormitories were very bare and there was a complete absence of furnishings, curtains, rugs, particularly on the male side.

(j) Complete custodial care and rigid segregation of the sexes. All doors were locked and the gates at the entrance had to be opened by the gatekeeper. Toilets have to be unlocked on request. Night toilets off dormitories are also kept locked and chamber pots were very much in evidence in dormitories. Shutters are still used on windows—this must be particularly depressing as most patients retire at 7 p.m.

(k) Patients still retire as early as 7 p.m. This is completely foreign to modern concepts of patient care.

Fortunately, these depressing comments did not apply to all hospitals, or to all parts of most hospitals. The following comments refer to two of the hospitals where considerable improvements have been carried out:

(1) The members were impressed by the reconstruction and rehabilitation of this hospital, parts of which have yet to be completed. The conversion work is a first-class job, executed with imagination and excellent taste; it shows what can be done to rehabilitate the structure of an old hospital. Standard of cleanliness was quite good; the furniture, furnishings etc. were good; ancillary services were better than in most mental hospitals; chiropody services were provided as well as very well-equipped hairdressing salons for male and female patients; the atmosphere of the hospital was obviously good.

(2) The hospital was structurally good and there was good adaptation of old buildings. In the main building, by a lot of effort and imagination, wards had been made physically comfortable. There was plenty of " drive " evident throughout the hospital and there was a good programme of recreational activities; medical and nursing care was adequate; out-patient and domiciliary services appeared to be satisfactory.

Expert examination will be necessary to determine what hospitals, or parts of hospitals, are suitable for the care and treatment of long-term patients. Clearly some buildings are suitable. Equally clearly some should be demolished and replaced by new buildings; others can be reconstructed and brought up to suitable standards. **The Commission recommends that every health authority should arrange to have a detailed survey carried out, with such expert advice and assistance as may be specified by the Minister for Health, to determine:—**

(a) what buildings are suitable for retention on a short-term and on a long-term basis;

(b) what improvements are necessary and what additional facilities are required at the buildings to be retained;

(c) what buildings need to be replaced.

The Commission accepts the concept of the comprehensive hospital

and it considers that, where feasible, there should be integration of psychiatry and general medicine at all levels. Accordingly, it recommends that when new buildings are required the desirability of placing them at a general hospital should be considered.

The traditional forms of in-patient accommodation are not the most suitable for modern treatment programmes. In planning new buildings regard should be had to the techniques and designs adopted recently in other countries. Frequently it will be found desirable to provide buildings similar to ordinary dwellings, rather than large hospital-type units. The aim should be to provide a residential setting which can be developed to provide a comprehensive rehabilitation hospital.

(c) THE ROLE OF PRIVATE MENTAL HOSPITALS AND HOMES

General

68. At Appendix H is a list of the thirteen private mental hospitals and homes. The term " private " is here used as a general term to distinguish these centres from the local authority or public hospitals. The private hospitals and homes vary to a very great extent; one caters for only one patient—another had 1,969 admissions in 1965; some are staffed and equipped as full psychiatric hospitals and make a considerable contribution to the mental health services of the country —others could be described as nursing homes providing useful and desirable services but filling a limited role only and catering for the less difficult forms of mental illness; some are privately owned—others correspond closely to the voluntary general hospitals; some are operated for profit—others provide charitable services to a considerable extent; some have out-patients clinics—most have not. Health authorities have power to send patients to private hospitals and homes and to pay for them at approved rates (varying from £5. 10. 0. per week to £11. 11. 0.) but this power is not used to an appreciable extent. There is, however, a provision in the Health Act, 1953, under which a person who is entitled to receive treatment free, or at a reduced rate, in a district mental hospital, may obtain a contribution towards the cost of his treatment in **a** private hospital or home. Considerable use is made of this provision. At present the contribution payable varies from £6. 6. 0. to £8. 1. 0. per week. The period of payment is in all cases limited to 13 weeks.

Classification

69. For the purposes of the registration and the reception and detention of patients, private mental hospitals and homes are divided into four classes (see Chapter 10). There are only technical differences between the four classes. For practical purposes, therefore, the private mental hospitals and homes are treated, to a very large extent, as a homogeneous group notwithstanding the very wide differences in the scope and nature of their activities. **The** Com-

mission regards this position as unsatisfactory and considers that they should be classified as psychiatric hospitals and as psychiatric nursing homes, as is done in the case of centres catering for the physically ill.

Private Psychiatric Hospitals

70. The Commission considers that, where a private psychiatric hospital corresponds closely in its organisation and in its work to a voluntary general hospital, and is staffed and equipped to provide a satisfactory public service, it should be treated for the purposes of the health services in the same way as a voluntary general hospital. If this were done, a psychiatric hospital would be paid at rates approved by the Minister in respect of all patients who were eligible for treatment free, or at a reduced rate, and who were sent, or were deemed to be sent, to the hospital. (In Dublin, any eligible patient admitted to a voluntary hospital is deemed to have been sent there by the health authority). For recognition as a psychiatric hospital a centre should be required to satisfy the Minister for Health that:—

(a) it is adequately staffed and equipped to deal with short-term patients, or long-term patients, or both, or is suitable for the short-term care of a particular class of patients, e.g. alcoholics; and

(b) it operates an out-patient service.

Private psychiatric hospitals fulfilling these conditions can make an important contribution to the range of psychiatric services, and it is desirable that their contribution and potential should be taken into account when determining the extent of the services which it is necessary for health authorities to provide.

Psychiatric Nursing Homes

71. Physically ill patients are not sent by health authorities to nursing homes, but persons who are entitled to receive treatment free, or at a reduced rate, may obtain a contribution towards the cost of their treatment in an approved private nursing home. The period of payment is, in all cases, limited to six weeks unless the health authority decides otherwise. **The Commission considers that, in view of the nature of mental illness and the relatively long treatment period required by many patients, contributions should be paid as at present for a period of 13 weeks. In other respects it considers that psychiatric nursing homes should be treated in the same way as nursing homes for the physically ill.**

CHAPTER 5

COMMUNITY SERVICES

Introductory

72. A re-awakening to the importance of social factors in the causation and treatment of mental illness has occurred in many countries in recent years. In the last century an English psychiatrist, Henry Maudsley,* wrote: " Insanity means essentially that such a want of harmony exists between the individual and his social medium, by reason of some defect or fault of mind in him, as prevents him from living and working among his kind in the social organisation." The policy of segregating and isolating the mentally ill in large hospitals ignored the social factors. With the growing appreciation of the fact that institutional life can be emotionally, physically and socially disabling in its effects, there has come a realisation that many disabled persons can be treated, with increased prospects of success, in their normal social environment, or in an environment as near as possible to normal. The advent of drug therapy and the increased understanding of mental illness has facilitated the care and treatment in the community of many persons who, in the past, would have been cared for in hospital. So great has been the swing away from hospital care that there is a danger that community care can become a catch-cry and that mentally ill patients may merely exchange neglect in a hospital for neglect in the community. **Community care undoubtedly is desirable, but its success depends upon the development of a number of special facilities within the community.** These are discussed in the following paragraphs.

Out-patient Clinics

73. **The first essential of community care is specialist out-patient psychiatric clinics.** The primary purpose of such clinics is to provide diagnostic services for the mentally ill, to make available consultative opinions for family doctors and other non-psychiatric physicians, and to provide treatment of a kind which is not within the range of the general physician. The development of out-patient clinics permits the early diagnosis and treatment in the community of many patients who otherwise would have to enter hospital and who possibly would not do so until their illness had reached an advanced stage and had become difficult to treat successfully; it enables many general practitioners to treat, in the community, conditions which otherwise would require care in hospital, and it permits the early discharge from hospital of patients who can receive at the clinic advice and follow-up treatment which otherwise would have to be provided in a hospital.

•Body and Mind—London 1873. Second Edition.

In Ireland out-patient attendances increased from 7,386 in 1956 to 83,769 in 1965; over the same period the annual total number of patients attending clinics increased from 2,816 to 25,417. While this substantial increase indicates a growing appreciation of the need for, and the advantages of, out-patient services, the Commission is satisfied that there is room for further considerable development. Out-patient clinics have not been developed uniformly throughout the country and many areas are still badly served. Significantly, it is these latter areas which show the least success in reducing the demand for in-patient accommodation. Again, even in some areas where out-patient services are relatively well developed, the emphasis tends to be on diagnosis and only limited treatment procedures are provided in clinics. In some areas clinics are held so infrequently that they cannot make any really effective contribution to the treatment of patients. Many of these deficiencies can be traced to lack of staff but this difficulty should be overcome by the increases in staff which the Commission has recommended in Chapter 4. **The Commission recommends that the extensive development of out-patient services should be given a high priority in the programmes of all health authorities.** Some clinics should be held in the evening to cater for patients who are at work during the day. Such clinics would be particularly appropriate in urban areas. In addition to diagnosis, clinics should undertake treatment procedures such as E.C.T., psychotherapy and abreactive therapy. **The Commission wishes to stress that attendance by a psychiatrist does not necessarily constitute an out-patient clinic service.** The services of a psychologist and **a** psychiatric social worker are also desirable and, in the case of treatment clinics, the services of other professional grades, such as an anaesthetist, may be necessary. The requirements of special classes of patients, such as children and adolescents, are discussed in Chapter 6.

Domiciliary Consultations

74. Patients who can attend at out-patient clinics should be encouraged to do so. The number of psychiatrists available is limited and obviously it would not be feasible for them to provide domiciliary consultations on **a** large scale. Occasionally, however, a domiciliary consultation may be desirable. The patient may be unable or unwilling to attend the clinic and domiciliary consultation may be the only alternative to admission to hospital. Experience has shown that a domiciliary consultation with the family doctor may be educationally beneficial for the family and the family doctor, and thus the benefits of the consultation may extend far beyond the particular patient involved. **The Commission recommends that provision should be made for domiciliary consultations. Where possible, such consultations should be held in company with the family doctor. The Commission wishes to stress, however, that even though it is a valuable part of the service, domiciliary consultation should be used only to a limited extent—its use on a large scale**

would be wasteful of limited staff resources and could be undertaken only at the expense of out-patient and hospital services.

Day Hospitals

75. A day hospital is a hospital where patients attend for treatment during the day, returning to their own homes at night. Such hospitals can provide a very valuable form of care and treatment. Among the advantages claimed for the day hospital are the following:

(i) It avoids the institutionalisation of the patient who requires long-term treatment.

(ii) It prevents the shock which many patients feel on admission to a mental hospital.

(iii) It prevents the breakdown of home ties and the difficulty, frequently experienced, of obtaining employment after a stay in a mental hospital.

(iv) It makes possible the treatment in the community of many patients who require more intensive therapy than can be provided at a clinic and for whom the only alternative is admission to a mental hospital.

(v) It facilitates the earlier discharge of in-patients who can continue necessary treatment on a day basis.

(vi) It helps patients to readapt themselves to outside surroundings after a stay in hospital.

(vii) It permits many patients who are unwilling to enter **a** mental hospital to obtain necessary treatment.

(viii) It saves hospital beds. (In most countries there is a lack of suitable residential accommodation and the capital cost of providing it is very high.)

(ix) It is cheaper than residential hospital care. (A day hospital, because of the saving in sleeping accommodation and other ancillary accommodation, can cater for nearly twice as many patients in the same floor-area as a residential hospital. One shift of nurses is sufficient to deal with the patients, who usually attend for approximately an 8-hour day on 5 days a week. The cost **of** caring for a patient in a day hospital is stated to be only one-third to one-half of that of a patient in a residential mental hospital. Against this, some authorities maintain that the day hospital creates a demand for psychiatric care and that many patients attend for treatment who would not go to a mental hospital and that, therefore, the total cost may not be materially less than the cost of sending to a mental hospital such proportion of the patients as would enter there normally.)

The day hospital is a comparatively recent development and can be regarded as still in the experimental stage. A clear pattern has not emerged as to what its location, size, types of patients, and range of treatments should be. Some day hospitals are attached to, or linked with, parent mental hospitals; others are attached to, or linked with, general hospitals or other institutions. Some are separate buildings, others consist of a ward or wards of a hospital. Some share facilities with a residential hospital and day patients mix with resident patients; others provide their own facilities and day patients are kept distinct from resident patients. In some day hospitals almost the full range of treatments of a psychiatric hospital is available ; in others the range of treatments is limited—the day hospital acts more as an occupational centre, a sheltered workshop, or a social club. Some day hospitals cater for a wide range of patients—practically all the types found in a mental hospital; others deal only with a limited class of patients—possibly only those who can be dealt with as a homogeneous group. Some provide transport facilities, others cater only for patients who can make their own arrangements for travel. The size of a day hospital, the staffing and the facilities provided vary according to the population served by it and the use which is made of it. The Commission does not think it necessary to enter into the merits of the various types of day hospital. **It recommends that day hospital facilities should be provided at each of the psychiatric units** in, **or associated with, general hospitals. It recommends also that day hospital facilities should be provided at the short-stay units and at the long-stay units at mental hospitals. The day hospital unit should provide all the therapeutic facilities of the parent hospital.**

The Commission is glad to learn that a day hospital has been established recently in Dundalk and it recommends that two further separate day hospitals should be provided—one in Dublin and one in Cork. On the basis of the experience gained from the operation of these hospitals, the question of providing further separate day hospitals can be considered.

Social Work

76. Many of the mentally ill require the help of a social worker if they are to remain in, or be returned to, the community. A number have inadequate personalities and their sense of inadequacy is exaggerated by their illness; some feel insecure and unable to cope with their problems; others need help to obtain employment or to give their employers a greater understanding of mental illness; some need the re-assurance of the psychiatric services, so that they can receive advice or treatment when necessary ; many need help to obtain the various forms of social assistance or health benefits which are available; some need help in their domestic affairs and in their relations with their families and friends, or help in adjusting themselves to life and work in the community after a period in hospital; some need encouragement to attend their family doctor, to attend at clinics for

treatment or to take part in social activities. In all these spheres, **a** social worker can be of immense assistance and with his or her help many patients, who would otherwise require residential care, can remain in or return to the community. In addition to direct assistance to the patient, the social worker can obtain full information regarding the patient's background; this considerably helps the psychiatrist to understand the patient's problems and to arrange an appropriate course of treatment. The social worker can also arrange and supervise the boarding-out of patients in family care and assist in and encourage the formation of social clubs (see paragraphs 80 and 85). Another important function of the social worker is to help and advise the relatives or friends with whom the patient is living.

77. There are many categories of social workers, but two main grades are concerned with services for the mentally ill—psychiatric social workers and social workers. The respective roles and functions of these two grades and the training necessary for qualification are discussed in Chapter 8. To some extent their roles and functions overlap those of psychiatric nurses and public health nurses engaged on domiciliary work and community nursing. The Commission wishes to stress that nurses cannot be substituted for social workers in any organised scheme of psychiatric services, as they have not acquired the special skills necessary to undertake case work, which is an essential feature of the social worker's role. They do, however, play a complementary role in community care, and both nurses and social workers should be aware of this fact.

The Commission **recommends that every health authority should employ sufficient psychiatric social workers and social workers to meet the needs of its area.** Apart from work with individual patients, the psychiatric social worker should be responsible for the co-ordination of social work for the mentally ill. It is not possible at this stage to estimate the number of social workers of each grade required, because the Commission envisages that, in addition to undertaking social work with psychiatric patients in a particular district, a social worker would also have duties in regard to other branches of the health services.

Family Care

78. Family care may be defined as placing patients in the private homes of paid guardians or sponsors under general psychiatric supervision. It is referred to variously as "Boarding-out", "Family Care", "Home Care", "Family Nursing" and "Foster Home Care". In discussing the benefits of family care, Dr. J. K. Wing states* "**The** system is claimed to be economic because hospital bed-space is released, the cost per patient may be less, and the patient may be able to do valuable productive work; humanitarian, because of increased privacy, freedom, dignity and responsibility; social, in that the gulf between society and the patient is

•**Lancet 1957, 2, 884-885.**

more easily bridged; therapeutic, since there may be good opportunities for rehabilitation and eventual discharge". Many psychiatrists who have had experience of family care have expressed the view that it forms an effective means of treatment and they have noted unmistakable improvements in many " chronic" patients; paranoid trends have decreased in their intensity and catatonic patients have become more alert. As Mayer-Gross, Slater and Roth have written, " the aim is to absorb the life of the patient not only into that of the guardian's home but also into that of the local community ".*

During the past 100 years family care of the mentally ill has developed in many countries including America, Belgium, Britain, Denmark, Finland, France, Germany, Holland and Norway, but it has been used only to a negligible extent in Ireland and it was not until the advent of the Mental Treatment Act, 1945, that it was placed on a legal basis as a means of caring for the mentally ill. The system visualised in that Act was based mainly on the Scottish system. Briefly, the Act provides that a mental hospital authority may board out in a private dwelling any person detained in a mental hospital who is not dangerous to himself or others, provided that the person in charge of the dwelling is trustworthy, and that no other person is boarded-out in the same dwelling. The Home Assistance Officer must visit each patient not less often than once in every three months and a medical officer from the hospital must visit the home not less than twice each year. All visits must be recorded in a special book kept by the guardian.

79. The Commission considers that properly supervised family care provides an effective way of treating certain classes of mentally ill patients in the community. In particular it would be appropriate for the following categories—

(1) long-stay patients who have recovered but who are unable to return to the community because of the severance of family ties during their period of hospital care, e.g. patients whose parents are dead and whose brothers and sisters are married with young families. Practically every mental hospital in Ireland caters for a number of such patients at present;

(2) patients with residual symptoms such as hallucinations and delusions with which they have come to terms, or with peculiarities of conduct. In other countries these categories are discharged to the community, but they appear to require greater support than can be provided by the social worker service and consequently are re-admitted frequently for periods of hospital care. Many of these patients might be more successful in their efforts to fit into the community if they were placed with sponsors who

•Clinical Psychiatry. W. Mayer-Gross, Eliot Slater and Martin Roth (1960).

would contract to take an interest in their welfare and to afford them daily supervision, guidance and occupation;

(3) patients who, though clinically improved, are socially disabled in that they are unable to live independently outside hospital and have a history of frequent re-admission;

(4) convalescent patients who may make a better adjustment if family care is used as a half-way house between the organised life of a hospital and complete self-sufficiency in the community;

(5) psychotic and emotionally disturbed children and adolescents who may re-adjust themselves if removed temporarily from their usual home environment.

80. **The Commission recommends that, in the future organisation of services, provision should be made for a properly supervised system of family care, closely linked with the general scheme of psychiatric services.** The restriction in the present system that only one patient can be boarded-out in any one dwelling appears to constitute a grave weakness in practice and should be removed. Long-stay patients selected for transfer to family care should be given a very careful preparation before placement. They should be taught gradually to assume responsibility and they should be re-educated for life outside the hospital.

Hostels

81. The term " hostels " is used to describe places where board and lodgings and recreational facilities are provided for the mentally ill, but where the full range of services available in a mental hospital is not provided. A measure of support may be provided in such hostels similar to that made available by social workers for the mentally ill in the community. Hostels can fulfil a number of purposes in the care of the mentally ill. They can serve—

(a) as half-way houses where persons can stay for a time after discharge from hospital and before their full absorption into the community. For many of the mentally ill, particularly those who have been in hospital for a long time and those who have no relatives ready to receive them, the change from the sheltered life of the hospital to full life in the community frequently is very difficult. The hostel can bridge the gap between the hospital and the community and enable many to graduate to life in the community who otherwise would not be able to do so;

(b) as centres from which persons can attend for industrial training or sheltered employment—those who do not need the full resources of the mental hospital but are unable to lead an independent life in the community;

(c) as centres from which persons can attend day hospitals—those who are in need of psychiatric treatment which cannot be given in the home but do not need the full resources of a residential hospital;

(d) as testing grounds to decide whether patients can live in the community. A psychiatrist often is reluctant to discharge a patient from hospital when his family is not prepared to accept him, when he is reluctant to leave hospital, or when there is doubt as to whether he will be able to cope with life in the community. The psychiatrist can watch the patient's progress in the more normal environment of the hostel and can arrange for his immediate return to hospital, if necessary.

Hostels do not need staff or equipment on the same scale as mental hospitals. They are therefore easier and cheaper to provide and they can be as good as a mental hospital for some patients and better for others. **The Commission regards the provision of hostels as very desirable, provided they are integrated in the other psychiatric services. It regards it as essential that the purpose of hostels should be borne clearly in mind, that they should be used only for patients for whom they are suitable and that they should not be used as second-class hospitals for patients who require care and treatment in a hospital. In particular, it regards it as essential that adequate supporting community services should be available before hostels are developed on an extensive scale.** It is not possible to estimate the number of places required in hostels—it depends on factors such as the development of day hospitals, industrial training, sheltered employment and other community services. **The Commission recommends that health authorities should arrange for the provision of a number of hostels on an experimental basis in the larger centres of population.** Such hostels could be provided readily by adapting large residences in suitable urban areas.

The Role of the General Practitioner

82. In the past, psychiatry was almost unknown territory as far as many general practitioners were concerned. Their training was concerned primarily with physical illnesses which cause pain or threaten life and they were not asked to take an interest in mental health. The isolation of the mental hospital and the emphasis therein on custodial care helped to keep the general practitioner uninterested in psychiatry and largely unaware of its implications. At present much remains to be done before the training of doctors can be regarded as satisfactory (see Chapter 8), but the general realisation of the extent of mental illness, the extra-mural activities of psychiatric hospitals, and the greatly increased effectiveness of psychiatric treatment, have awakened a general interest in psychiatry, and most doctors are willing and anxious to co-operate in the treatment and control of mental illness. **If community care**

of the mentally ill is to be effective, the general practitioner has a vital part to play. Because of his accessibility to, and his knowledge of, the patient and his family, frequently he is the first to be in a position to recognise the symptoms of mental illness. It is important that he should be able to do so and that, having recognised the symptoms, he should know how much he himself can do and when further help is required. The general practitioner is fitted to carry out certain types of psychiatric treatment, but not all. The ready availability of consultant services will help him considerably. If the patient has to be referred for psychiatric treatment, either in-patient or out-patient, the general practitioner should be able to explain the nature of the treatment available and what can be expected from it. He can assist considerably in influencing the attitude of the family towards the patient and can help to prevent the rejection of the mentally ill, which results only too often from ignorance and out-moded beliefs. After a period in hospital a patient frequently can be returned to the care of the general practitioner. In such cases it is essential that the general practitioner should be informed fully of the treatment provided in hospital and of any recommendations for further treatment which the consultant considers desirable. **Unless there is close co-operation and adequate communication between the specialist psychiatric staff and the general practitioner, community care will not be effective. The Commission recommends that general practitioners should be appointed as clinical assistants in psychiatric hospitals, particularly in long-stay hospitals, to assist in the psychiatric, as well as in the physical, care of patients. This should serve to foster co-operation between the general practitioner and the psychiatrist.**

The Role of Public Health Personnel

83. Community services for the mentally ill should form part of, and be co-ordinated with, the general programme of preventive and curative medicine. Public health staff, through their numerous contacts with the public, can assist in the promotion of mental health and help to create a better understanding of the problem of mental illness. **Public health personnel accordingly should play a far greater part than heretofore in the promotion of mental health and in the provision of services for the mentally ill.** The Commission considers that public health personnel through their contact with the public through maternity and child welfare clinics, school medical inspections, domiciliary visits, industrial medicine, the inspection and allocation of houses and the payment of disabled persons maintenance allowances, frequently will be the first to suspect mental illness, and they can encourage the persons concerned to obtain suitable medical care. Help of various kinds may be provided for the mentally ill by persons such as public health nurses who also provide services for other sections of the community. Additional services, such as vocational assessment and placement, are needed also for different sections of the community; they may be provided by public health

staff, or by separate agencies. In the latter case the Chief Medical Officer should endeavour to co-ordinate the work of the different agencies concerned.

The Role of Voluntary Agencies

84. In the past, voluntary agencies have played a relatively small part in providing services for the mentally ill in this country. In recent years there has been a very welcome increase in voluntary effort. Associations of friends of different mental hospitals have been formed, and voluntary organisations established for other purposes have interested themselves in the problem of mental illness. The formation of an industrial therapy organisation within the framework of a National Association for Mental Welfare is being considered. These developments are most welcome, but the total voluntary effort devoted to mental illness is still small and compares unfavourably with that in many other countries. The scope for voluntary organisations in helping to care for the mentally ill is very wide—in particular, they can assist the mentally ill in hospital, and can help them to retain their interest in the outside world and to realise that they have not been abandoned; they can organise entertainments of many kinds and interest the mentally ill in a variety of hobbies; in appropriate cases, they can arrange visits to the mentally ill in their own homes; they can operate clubs; they can help the mentally ill to secure and retain employment, and do much to create an informed public opinion and a more enlightened approach to the problem of mental illness. **The Commission considers that the activities of voluntary organisations should be encouraged, and accordingly recommends that, where necessary, health authorities should contribute to their funds to enable them to engage in suitable activities on behalf of the mentally** ill. **While the scope for voluntary organisations b great, they need the backing and guidance of professional skills. Accordingly, the Commission further recommends that voluntary organisations providing services for psychiatric patients should be encouraged to develop close associations with health authority and other skilled personnel providing psychiatric services.**

Clubs

85. After discharge from hospital, many of the mentally ill miss the security of the hospital and the companionship of a number of people. Particularly in the period immediately following discharge, they may find it very difficult to adjust themselves to life in the community. Clubs where they can give one another mutual support and where there is sympathy with them and understanding of their problems have been found most useful. Clubs catering for psychiatric patients fall into two main groups :—

(1) clubs closely associated with psychiatric hospitals, which provide **a** supporting social milieu for patients in the period

immediately following discharge from hospital—in some cases these are organised and managed by the hospital staff;

(2) clubs which provide a similar milieu for former patients who have adjusted themselves reasonably well to living in the community, but who, in order to maintain this position and avoid further periods of hospital care, need the stimulus of social contacts which they cannot effect themselves except in a club where their needs are understood.

The formation and operation of such clubs is a very suitable field of activity for voluntary organisations. They should receive financial support from health authorities. The backing and guidance of professional skills are essential. These will be available readily to clubs in the first category. Those responsible for operating clubs in the second category should make every effort to foster close working relationships with the professional psychiatric staff in their area. Social workers should help with both types of club.

Financial Assistance to the Mentally III

86. If the services recommended in this Report are developed many patients suffering from forms of mental illness which now require in-patient treatment will, in future, live in the community. Some of these will be dependent or semi-dependent and they will require financial support. At present some such persons are paid Disabled Persons Maintenance Allowances. **The Commission considers that the payment of these allowances forms an effective and convenient system of providing financial support for mentally ill persons in the community and strongly recommends the widest possible use of the system in future.**

CHAPTER 6

PROVISION FOR SPECIAL CLASSES

General

87. The provisons suggested in Chapters 4 and 5 will make available the services required by the majority of the adult mentally ill. There are, however, a number of the mentally ill for whom special provisions are necessary, either separately or in conjunction with the services already outlined. These include children, adolescents, certain aged persons, alcoholics, drug addicts, sexual deviates, epileptics, psychopaths, persons in custody and homicidal and very violent patients. Proposals in regard to these classes are made in paragraphs 88-134.

(a) CHILDREN

General

88. A number of children are found to suffer from conditions which require psychiatric care. These conditions may vary from a transient emotional disturbance to a severe psychosis needing prolonged and intensive in-patient care. There is no generally accepted classification of psychiatric conditions in childhood and terms such as emotional disorder, maladjustment and autism may not convey the same meanings to different people. Children may suffer from more than one condition at the same time and the seriousness of a particular condition depends not so much on its nature as on factors such as its degree of severity and the length of time it persists. The Commission did not consider it necessary to define the various terms in use. Diagnosis of the nature of the condition and assessment of its degree of severity are important in the individual case, but in relation to the organisation of services it is only necessary to consider the range of services required by children as a class. The Commission did not consider services for the mentally handicapped as such; this class has already been considered by the Commission of Inquiry on Mental Handicap, which reported in 1965. However, from time to time it may be difficult to decide whether particular individuals should foe catered for by the services for the mentally ill, or by the services for the mentally handicapped; consultation between those operating the two services frequently will be necessary: Subject to this, the Commission considers that, in general, children who are primarily mentally handicapped should be dealt with by the services for the mentally handicapped, even though they may have emotional or psychotic symptoms, and that persons who are primarily mentally ill should be dealt with

by the services for the mentally ill, even though they may suffer from some degree of mental handicap.

Prevalence

89. At present, statistics of the total number of children in this country in need of psychiatric care are not available—indeed, reliable statistics are not available for any country. Estimates made in other countries vary from 1 per cent to 20 per cent or more of the child population. This wide variation may well be due mainly to the use of different diagnostic criteria, but it is probably due also, to some extent at least, to confusion between the numbers becoming in need of services each year and the numbers in need of services at a particular time. Where services are not provided or are inadequate, the latter number will be much in excess of the former, as it will contain a backlog of cases which had failed to obtain treatment at the appropriate time. Experience has shown that, in the initial stages of the provision of a psychiatric service for children, the number coming forward for treatment is substantially less than the number theoretically requiring it, but that as the service is developed, the benefits of child psychiatry are more and more appreciated and the demand for the service increases. In Ireland about ten years ago there was only one complete Child Guidance team. Now there is the equivalent of about six teams and most have waiting lists. **The Commission recommends that the aim should be to develop the equivalent of at least one Child Guidance team per 100,000 of the total population of all ages.** This is much lower than the target set in several other countries but, as services are developed, the actual needs will become clearer and if the provision suggested is found to be inadequate it can be increased. Residential care, as detailed in paragraph 93, will be required for approximately 180 children.

District Child Psychiatric Clinics

90. **To provide for the diagnosis, assessment and treatment of children, the Commission considers that district child psychiatric clinics should be developed.** These district clinics would cater for the majority of children who can be dealt with on a community basis, but would refer appropriate cases to regional clinics (see paragraph 92), or to residential centres (see paragraph 93) when necessary. District child psychiatric clinics are necessary **so** that services can be brought within easy reach of the majority of children. In addition, child psychiatry is essentially family psychiatry. A child is treated usually within the family setting, and persons in his immediate environment also may need treatment or guidance because of their close relationship to him and to his condition. The co-operation of the family is necessary if treatment **is** to be effective. Indeed in many cases treatment consists in giving parents re-assurance and advice on how to deal with the child's problems. Accordingly, it is desirable that, as far as possible, persons dealing

with the children should be closely in touch with the problems of the family. The Commission has recommended in paragraph 73 the development in the community of psychiatric clinics for adults. It similarly recommends the development of clinics for children, but at different times from those for adults. Child psychiatric services involve a team approach. A psychiatrist, a psychologist and a social worker are the basis of the team, but they should be in a position to enlist the help of others where necessary. A basic team should be available at the district clinics and the psychiatrist on the team should have a minimum of one year's experience in child psychiatry. The Commission recommends that each health authority, or organisation, conducting district clinics should have such a psychiatrist on its staff, or should arrange with another body e.g. that conducting a regional clinic, for the attendance of a psychiatrist with such experience. It is most desirable that district clinics should operate in close association with the school medical service and the school psychological service and with family doctors and paediatricians serving the area in which it operates.

Ascertainment and referral

91. The detection in children of conditions which require psychiatric advice or treatment is a matter in which different people may be involved. Parents are frequently the first to notice and to seek advice regarding unusual behaviour in their children. Nurses visiting the home may notice deviations from the normal, or recognise conditions likely to lead to such deviations. Doctors conducting child welfare clinics can detect cases in need of treatment at an early date. General practitioners can play an important role; usually they are the first to be consulted by parents who are worried by their children's symptoms. Often they have care of children from birth and because of their knowledge of the family they will be aware of conditions likely to lead to psychiatric disorder in the children. Paediatricians are trained to recognise abnormal behaviour at a very early age. They are frequently the first to be consulted about an emotional illness which shows itself as a physical symptom. Many cases will be discovered through services associated with schools, since the growth of personality disorders frequently results in a loss of scholastic achievement, in a failure to form social relationships with other students or in abnormal patterns of behaviour in school. In relation to these children, teachers, school psychologists and school medical officers are, therefore, in key positions. It is understood that greater emphasis is now being placed on the study of child development in training and refresher courses for teachers. The Commission welcomes this development. The Minister for Education recently has employed a number of psychologists and has announced his intention of developing a school psychological service. The Commission also welcomes this development. It regards an adequate school psychological service as an essential feature of any programme of mental health for children.

The importance of training School Medical Officers to enable them to recognise incipient mental disorders in children need not be stressed. **Most cases probably will be referred to district clinics through the Chief Medical Officer, either because they have been discovered through the Child Welfare Services, or medical services for the schools, or because other doctors find it convenient to make the necessary arrangements through him. The Commission recommends, however, that any doctor should have the right, if he so desires, to refer a child directly to a district clinic.**

Regional Child Psychiatric Clinics

92. **The district child psychiatric clinics will be able to deal with most problems in children, but the Commission regards it as necessary that regional child psychiatric clinics should also be developed.** The regional clinics could act as district clinics for children in their immediate areas, but their primary purpose would be to deal with cases presenting particular difficulties, or requiring facilities not available at the district clinics. The staffing of the regional clinics should be based on a child psychiatrist, a psychologist and a psychiatric social worker, but provision would be necessary for consultation with other specialists, such as paediatricians, and a wide range of ancillary staff, such as speech therapists, would be necessary. It is also essential that facilities for special teaching (see paragraph 95) should be available. The psychiatrist should be fully qualified in child psychiatry. He would act as consultant to the district clinics. Short-term residential accommodation (see paragraph 93) would be required for children coming from a distance and requiring a period of extended observation or treatment. The Child Guidance Clinic, Rathgar, operated by the Hospitaller Order of St. John of God and the Child Guidance Clinic operated by the Sisters of Mercy at the Mater Hospital, Dublin, already provide most of the facilities the Commission has in mind. **It recommends that any additional facilities necessary to enable them to act as regional clinics should be provided. It also recommends that three additional regional clinics should be provided.** These should be situated outside Dublin. Cork, Limerick and Galway are probably the most suitable centres. The Galway clinic would have to cater for the north western portion of the country and might have to operate through a sub-regional clinic, which could best be located in Sligo.

Residential Accommodation

93. The majority of children in need of psychiatric care can be dealt with while residing in their own homes. Some, however, cannot be so treated because their illness is so severe, or is of such a nature, that it requires facilities which can be made available only in **a** residential centre. In addition, there are some children who should be removed from their homes, for a time at least, either because the environment in the home is such that successful treatment is not

feasible, or because their presence in the home seriously upsets other members of the family. The needs of children are complex and it would be wrong to assign them to different types of residential centres solely on the basis of a diagnostic classification. **Subject, however, to the condition that there will be considerable flexibility, and that each child will be assigned to the accommodation most suited to his needs, the Commission considers that four types of residential accommodation will be required** :

(a) Short-term units, mainly for diagnosis and assessment.

(b) Long-term units, mainly for psychotic and severely disturbed children.

(c) Medium-stay units, mainly for children with severe neurotic disorders, such as chronic school phobia, and children who require special treatment facilities in an environment which cannot be provided in their own homes.

(d) Units for children with psychosomatic disorders.

Short-term Units

Some children require an extended period of observation to permit of a proper diagnosis and assessment. It is impossible sometimes to provide this extended observation while they remain in their own homes, particularly if they live at a distance from a district or regional centre and it then becomes necessary to admit them to a residential centre for a short time. There are also some children who need a short period of in-patient therapy. In both cases the period of stay is short and normally would not exceed a few weeks, so that the total number of places required is relatively small. The Commission recommends that units should be provided at, or in conjunction with, some of the regional clinics referred to in paragraph **92. The Commission recommends mat, initially, a total of 20 beds should be provided.**

Long-term Units

A centre of the type referred to at (b) is already in existence at St. Loman's Hospital, Ballyowen, Co. Dublin. It has accommodation for 30 children and caters for Dublin mainly at present. It has a waiting list of 28 patients. As with other aspects of child psychiatric care, the statistics available are insufficient to permit of **a** firm estimate of the total number of beds required for long-stay cases. The matter has to be kept under review and the provision made adjusted to meet the known needs. It is apparent, however, from the figures available that **a** considerable increase on the present provision is necessary. **The Commission recommends mat 50 places should be provided in Dublin and that 2 additional regional units of 25 places each should be provided. Cork and Galway probably would be the most suitable centres for these units.**

Medium-stay Units

There is not at present a medium-stay unit of the type referred to at (c), except insofar as the unit at St. Loman's caters for a limited number of medium-stay patients. It is not possible at this stage to say how many places in medium-stay units will be required—apart from the absence of reliable statistics the matter will be affected by the rate of development of district and regional clinics and of facilities for special education. In 1961, the provision made in England and Wales for emotionally disturbed children in need of special education (this, broadly, is the same class as that visualised for the medium-stay units) was as follows :—

Boarded in special schools	1,591
Boarded in homes	715
TOTAL	2,306

On the basis of these figures approximately 170 places would be required in Ireland. However, this can be regarded as no more than an approximate guide to the country's needs, as the actual requirements will be affected by a number of unknown factors such as—

(a) the extent to which adequate hospital and school facilities can be organised on a day basis in Ireland where a considerable part of the population is thinly scattered over wide rural areas ;

(b) whether emotional disturbance is more prevalent or less prevalent in a population predominantly rural in character;

(c) whether emotional disturbance is more susceptible to treatment within the family in a rural population.

It is only as services develop that an accurate estimate of the need for residential places can be made. However, it is clear that there is a need for a number of places. **The Commission recommends, as an initial step, that a 30-bed unit should be established at or in association with one of the Regional Clinics referred to in paragraph 92.** As services are developed it probably will be found necessary to provide places at each of the Regional Clinics.

Units for Psychosomatic Disorders

Some children whose psychiatric disorder is accompanied by physical symptoms are treated in paediatric hospitals. Usually they are treated in the same wards as other children. Some can be treated suitably in this way, but others, such as those suffering from severe anorexia nervosa or faecal incontinence, require special staff and facilities and an environment suited to their needs. The total number of beds required is small—20-30 beds probably would serve the needs

of the country. **The Commission recommends that this number should be set aside in children's hospitals for children with psychosomatic disorders.**

Boarding-out in Family Care

94. The Commission has recommended in paragraph 80 that provision should be made for a properly supervised system of boarding-out in family care. **It similarly recommends that children who have to be removed from their own homes, but for whom care in a residential centre is not essential, should be boarded-out. Such children frequently suffer from emotional difficulties and exceptional care in the selection of families is essential. Only those families which will provide the environment the children need should be chosen.** As an alternative to the ordinary system of boarding-out children with a family, house parents could be selected and given charge of a house in which a small number of children could be placed, thus creating a family atmosphere. Children boarded-out could attend regional or district clinics or go out to day schools in the locality.

Education

95. Most children in need of psychiatric care can receive education in the normal school system. Some, however, fail to learn or to keep up with their contemporaries and require a special form of education. As yet, the provision made for such education is limited. There are schools at the Child Guidance Clinic, Rathgar, Dublin (average enrolment 26.6), at Benincasa, Sion Hill, Dublin (average enrolment 26.9), at St. Declan's, Northumberland Road, Dublin (average enrolment 32.9) and at St. Loman's Hospital, Ballyowen, Dublin (average enrolment 29.8). These special schools accept children who are emotionally disturbed, or have severe learning disorders and cannot be catered for in the normal school system. The Department of Education makes provision for schools at residential centres for the mentally handicapped. The Commission assumes that it will make similar provision for schools at the residential centres recommended in paragraph 93. The Commission considers also that special day-schools and classes should be provided for the emotionally disturbed who find difficulty in following a normal school curriculum. **The Commission recommends that initially day facilities, available at the Child Guidance Clinic, Rathgar, should be extended and that similar day facilities should be provided at the other regional centres. In addition it recommends that the Department of Education should investigate the possibility of establishing special classes in ordinary schools.** With the development of the school psychological service referred to in paragraph 91 it is probable that increased numbers of children who are in need **of** special education because of emotional difficulties will be discovered.

Failure to attend school may be due to phobia or emotional upset. School Attendance Boards should be encouraged to consult the staff of the child psychiatric clinics in regard to children who consistently fail to attend school.

Young Offenders

96. The causes of crime, even in children, are complex and the Commission does not believe that all children who appear before the Courts, charged with offences, are in need of psychiatric treatment. Delinquency, however, is frequently a symptom of emotional disturbance, or other psychiatric disorder, and the Commission considers that psychiatric services should be available to the Courts in respect of all children charged with offences who, in their opinion, display any signs of being subject to such a disability. **The Commission recommends that a psychiatric report should be available to the Courts in respect of those offenders who appear repeatedly before them, or whose actions seem to be irrational, and, in particular, in respect of all those whom it is proposed to commit to a residential centre.**

Children in industrial schools

97. Industrial school services (which are provided under the Childrens Acts 1908 to 1957), in general, are not within the Commission's terms of reference, but the Commission was concerned with the provisions made in such schools for psychiatric and psychological services and with the possible effect of the schools on the emotional development of children sent to them. It received views from various sources that the prevalence of psychiatric disturbance is high among children who have been in industrial schools.

Industrial schools cater for children of various classes—children committed by the Courts as offenders (these are a small minority); children committed by the Courts as non-offenders (e.g. as not being under proper guardianship); children sent by local authorities; and children sent by their parents or guardians. They contain many children who are deprived in some way. Many are without one or both of their parents, either because of death or the break-up of the home; many were suffering from emotional disturbance before they entered, or have become emotionally disturbed by the circumstances surrounding their entry; some are illegitimate and a considerable proportion suffer from lack of security. Children in industrial schools thus constitute a group whose emotional needs are far greater than those of normal children, and for whom psychiatric and psychological services are particularly necessary. The provisions made for these services are very often most inadequate. In many schools children are not properly segregated according to their educational, social and psychological needs. Although good work is done by several voluntary bodies, there is no proper system of aftercare. In many cases, the authorities **of** the schools appreciate that

their services have many deficiencies and have done what they can to meet them ; but, with their limited resources, they find it impossible to remedy these deficiencies within the present system. **The Commission recommends that, as a first step, arrangements should be made for the provision of psychiatric and psychological services in all industrial schools. It also recommends that the whole problem of industrial schools should be examined.** It regards the term " industrial", as applied to these schools, as obsolete and objectionable. It also considers it undesirable that various classes of children are sent to the schools without any proper provision for segregation according to their special needs.

(b) ADOLESCENTS

General

98. The period of adolescence cannot be exactly defined. It is the period of growing up, between childhood and adulthood, and, in terms of age, varies with individuals. It is a time of turbulence, but so wide is the range of fluctuation within the limits of normality in the adolescent that, at times, it is difficult to decide when a particular pattern of behaviour is indicative of abnormality. Most people pass through the period of adolescence without particular difficulty, but there are some who need help. Many can be catered for most suitably by the services for children. There are some, however, who are too far developed to be included in the services for children, but whom it would be undesirable to mix with adults and for whom special services are therefore necessary.

Counselling

99. Much of the abnormal behaviour of adolescence can be managed effectively by **a** combination of sympathetic understanding, patient tolerance and simple counselling. Counselling of adolescents is, of course, primarily the responsibility of parents, but it is a matter in which, in varying degree, clergy, teachers, general practitioners, public health personnel and others with whom adolescents come in contact, have a part to play. **Specialist staff in the psychiatric services should, where necessary, provide advice and assistance for those concerned with the counselling of adolescents. Where the problem is of sufficient gravity to warrant it, psychiatric advice should be provided for the adolescent at district or regional child psychiatric clinics or at adult clinics—whichever is most appropriate in the particular case.**

Youth Organisation

100. Youth organisations can exercise a considerable influence for good on young people. Effective youth organisation channels the

adolescent's exuberant energy into character-forming recreational and social activities in clubs and similar associations. Youth clubs are an essential feature of any service catering for the special needs of adolescents, provided that the needs of the club are never allowed to transcend the needs of its individual members. Frequently the unruly, the ungifted, or those who are not amenable—in effect the group most in need of help—are shed silently in order that a favourable public image of the club may be preserved. **The Commission recommends that the development of youth organisations should be encouraged, and that those in charge of them should have special regard to the needs of adolescents who may be suffering from mental illness or emotional disturbance.** The growth of public appreciation of these needs and the ready availability of consultant psychiatric services should be of considerable help in this regard in future.

Residential Requirements

101. Residential accommodation will be required for a number of disturbed adolescents. Some can be provided for suitably in the accommodation already suggested for children and some in accommodation for adults. **The Commission considers however that approximately 150 residential places, especially designed for adolescents and separate from accommodation for other age groups and classes, will be necessary and recommends that these places should be provided in conjunction with short-term psychiatric units.** In view of the relatively small number involved, the adolescent units must be provided on a regional basis. Dublin, Cork and Galway probably would be the most suitable centres. The units should be staffed on the same pattern as the psychiatric units in, or in association with, general hospitals, but the psychiatrists from the regional child psychiatric units should attend in a consultant capacity.

Juvenile Delinquency

102. In adolescents, as in children, delinquency may be **a** symptom of emotional disturbance or other psychiatric disorder. **The Commission recommends mat psychiatric services should be available, as recommended in the case of children, in respect of adolescents who appear before the Courts.** The general problem of juvenile delinquency is outside the terms of reference of the Commission, but, in its consideration of the psychiatric aspects of this problem, it visited some of the reformatories and places of detention. These institutions suffer from the same defects as industrial schools. Psychiatric and psychological services are most inadequate ; those in charge do not receive adequate information on the background of the juveniles sent to them, and there is no proper system of aftercare. The authorities of these institutions are aware of the present deficiencies and are anxious to have them rectified. **The Commission recommends that provision should be made for psychiatric and psychological services at each reformatory and place of detention. It**

understands that an Inter-Departmental Committee on the Prevention of Crime and Treatment of Offenders is already in existence. It recommends that this Committee, or a separate body, should examine the whole problem of juvenile delinquency.

(c) THE AGED

General

103. The general problem of the care of the aged is outside the Commission's terms of reference. However, it had to have regard to all the services available for the aged, as the mental health problems of most of the aged are inextricably entwined with the problems of their physical health and social needs. Surveys in other countries have shown that the prevalence of psychiatric and emotional disorder among the aged is very high. The extent to which these disorders occur and develop is affected by the general medical and social services provided for the aged—particularly by the amount of support they obtain in the community. The recent White Paper on the "Health Services and their Further Development" indicates that the Government's general aim is to encourage old people to stay at home and to try to ensure that assistance will be available, where needed, to enable them to do so without experiencing hardship or imposing too heavy a burden on their relatives. It is understood that an Inter-Departmental Committee has been appointed to survey the services provided for the aged and to make recommendations regarding the development and co-ordination of these services in the future. It is also understood that there has been a considerable increase in voluntary effort on behalf of the aged. The Commission welcomes all these developments and would like to emphasise the inter-dependence of all services for the aged. The psychiatric services already outlined will cater for many of the needs of the aged, but other services as outlined in paragraphs 104 to 106 are also important.

Diagnostic and Assessment Units

104. The aged frequently suffer from multiple handicaps and many have both physical and mental disabilities. It is difficult at times to decide which disability is cause and which is effect. There is a considerable volume of evidence to show that many elderly patients are not placed in the kind of hospital most appropriate to their needs. **The Commission recommends that Assessment Geriatric Units should be available where their condition can be fully assessed, in its physical, psychiatric and social aspects, before an appropriate programme of care is formulated.** Many of the aged who develop psychiatric symptoms do not require treatment in a mental hospital.

Early Discovery

105. It is vital that incipient mental illness should be detected without delay. Frequently the psychiatric problems of an old person come under observation only after some social or medical crisis has developed and when admission to hospital cannot be averted. The psychological impact of such an admission can be very severe on an old person; his roots in the community may be severed and permanent care in an institution may be rendered necessary. Every effort should be made to discover mental illness at the earliest possible date and to persuade the persons concerned to seek advice or treatment at an early stage when prospects of success are best. **The Commission recommends that all persons providing services for the aged should be trained to recognise the symptoms of mental illness and should be fully aware of the range of psychiatric service available.**

Co-ordination of Services

106. The provision of services for the aged may involve a large number of persons such as nurses, social workers, general practitioners, public health doctors, staffs of general hospitals, staffs of psychiatric hospitals and voluntary workers of various kinds. It is essential that the work of the persons and agencies involved should be co-ordinated to avoid wasteful overlapping and duplication and to ensure that each person is served by the agency best suited to meet his particular needs. **The Commission recommends that there should be close liaison and co-operation between all the staff and organisations providing services for the aged, particularly between the staff and organisations dealing with the physical and social problems of the aged and those dealing with their psychiatric problems.**

(d) ALCOHOLICS

General

107. Alcoholism is a disease and is regarded by the World Health Organisation as a major health problem. The concept of alcoholism as a disease is not new, or even recent, but its general acceptance has been hampered and confused by the diversity of the causes of alcoholism and the variety of alcoholic behaviour and because some people regard alcoholism merely as a moral problem. Despite the antiquity of alcoholism, only recently have national health authorities become aware of the formidable social and economic cost of the disease and accepted that it is a problem deserving urgent attention.

In the absence of general agreement on the causes of alcoholism, and with no more than limited success in its treatment, the medical profession has concentrated, for the most part, on the organic results of prolonged and excessive consumption of alcohol. Cirrhosis of the liver, cardiac degeneration, brain and nerve damage, as well as frank

mental illness, are the aspects which have been stressed in the standard text-books of medicine. The general practitioner, in particular, is seldom equipped with knowledge of the alcoholic process which would enable him to help in the prevention of alcoholism.

There is no universally accepted definition of alcoholism. To some authorities, the alcoholic must be physiologically addicted; to others, a grave disruption of the patient's social and interpersonal relations, due to regular and excessive consumption of alcohol, is a sufficient criterion of alcoholism. However, compulsive drinking is a common factor in virtually all the clinical definitions of alcoholic addiction and " problem drinking ". The most widely accepted description of the alcoholic process presents a variety of types of alcoholism, largely conditioned by cultural factors. The type most commonly encountered in Ireland is marked by recurring loss of control over alcoholic consumption after the first drink of each bout of drinking. To meet the apparent need for a practical criterion of alcoholism, the Commission considers that the term "alcoholic" should be confined to those people who cannot control their consumption of beverages containing alcohol. It would qualify this definition, however, by pointing out that, even before it reaches an advanced stage, the pattern of heavy drinking which often precedes addiction, has serious repercussions on the individual, causes stress to relatives and dependants and is detrimental to the social good. The need for better preventive and diagnostic measures is no less important than the provision of improved therapeutic and rehabilitative facilities.

There is probably no single cause of alcoholism. Almost certainly, the disease results from a combination of genetic, physiological, psychological and social factors. There is no known cure and treatment is directed towards enabling the patient to become a contented teetotaller. Despite an occasional report to the contrary, to enable an alcoholic to revert to moderate " social" drinking is not generally held to be possible; this is certainly the only safe assumption in rehabilitative therapy.

The treatment of alcoholism is still largely empirical, although psychiatric hospital therapy tends towards a standardised pattern of restoring the patient to physical health, teaching him the nature of his disease, exploring any contributory personal problems and reinforcing his resolve towards total abstinence. Experiments in behavioural or " aversion " therapy have not shown persuasive results, but techniques of this kind may be of marginal value in the treatment of some people. At the present stage of development in the therapy of alcoholism, achievement of a 60 per cent arrest rate is considered exceptionally gratifying. In Ireland alcoholism is treated to a limited extent by private medical practitioners. Some treatment is provided in general hospitals and in private nursing homes but, in general, alcoholism is treated most commonly and most actively in mental hospitals. All district mental hospitals provide facilities for the treatment of alcoholism, both on an in-patient and on an out-patient basis, but

most alcoholics are treated in private hospitals—in particular in St. John of God Psychiatric Hospital, Dublin, which has a special unit for alcoholics, and in St. Patrick's Hospital, Dublin. Most alcoholics are treated on a voluntary basis but provision for compulsory treatment of " addicts " is made in the Mental Treatment Act, 1945. For the purpose of compulsory detention and treatment, which is decided on medical recommendation, an alcoholic addict is defined as a person who, by reason of his addiction to intoxicants, is dangerous to himself or others, or is incapable of managing himself or his affairs, or is incapable of ordinary proper conduct, or is in serious danger of mental disorder. People compulsorily admitted as alcoholic addicts, either to public mental hospitals or registered private mental hospitals, are accepted as temporary patients and may be detained initially for a period not exceeding six months. This may be extended by a further period or periods, but the aggregate period of detention cannot exceed twelve months.

Prevalence

108. The prevalence of alcoholism in Ireland is not known. The absence of common standards in diagnosis, the degree of social concealment and the treatment of symptoms in isolation all help to obscure the epidemiological picture. As far as the Commission could ascertain, no detailed survey of the number of alcoholics in Ireland has been attempted. Estimates made have varied enormously. Surveys undertaken in America and Britain appear to show that Irish emigrants, or people of Irish decent, occupy a high place when alcoholics are classified by country of origin or by ethnic group. One apparently significant American finding (by Hyde and Chisholm)* suggested that the Irish led all other ethnic groups in chronic alcoholism as a reason for rejection for service in the American Army during World War II. Such surveys, however, cannot safely be regarded as indicative of the extent of alcoholism in Ireland. Emigrants and their immediate dependants are frequently subjected to exceptional social pressures conducive to heavy drinking. Moreover, their position in the host society is likely to compel them to avail themselves of the public services on which many survey statistics are based.

The following statistics of alcoholics actually received into psychiatric hospitals in Ireland in recent years are of interest although they do not indicate the full extent of the problem, because the number of alcoholics who present themselves for treatment falls far short of the total who need treatment.

	Voluntary Patients	Temporary Patients	**Total**
1959	309	**95**	**404**
1960	538	**96**	**634**
1961	591	**120**	**711**
1962	**697**	**88**	**785**

•Bales, R. F. Cultural Differences in Rates of Alcoholism. Quart J. Stud. Ale. 6,480^199. 1946.

While separate figures for first admissions are not available in respect of these years, it is understood that of 1002 alcoholics (862 male and 140 female) admitted to mental hospitals during the nine months ended 31st December, 1963, 465 (403 males and 62 females) were first admissions.

It is also of interest to note that the per capita consumption of alcoholic drink in Ireland is one of the lowest for all countries for which reliable statistics are available. The Commission of course appreciates that the per capita consumption of alcohol is little, if any, guide to the extent of alcoholism and may be particularly misleading in a country, such as Ireland, where a very high proportion of the population have made solemn pledges not to take any alcohol.

Firm conclusions about the prevalence of alcoholism in Ireland cannot be drawn from available statistics. **The Commission* however, is satisfied, on the basis of the experience of psychiatrists practising in Ireland and daily dealing with its effects, that the problem of people who cannot control their consumption of beverages containing alcohol is a very serious one which requires immediate attention.**

Community Treatment Facilities

109. **The Commission considers that the treatment of early or uncomplicated cases of alcoholism can be undertaken most effectiyely in the community by general practitioners working in close association with psychiatrists.** This approach is more likely to influence relatives and friends to adopt an enlightened attitude towards the problems of the alcoholic and to make a more positive contribution to his rehabilitation. Moreover, because it is undertaken in a setting where the patient is subject to the stimuli which influenced the formation of his drinking habits, treatment can be more positively directed towards inimical influences in the patient's environment.

Probably the most important single factor in the successful treatment of alcoholism is the personal influence of the doctor. The general practitioner, because of his special relationship with his patients and their families, can be a most effective therapist, provided that he has some technical knowledge as well as a sympathetic, understanding approach to the problem. He can be of particular value in noting the personality changes, the family tensions, and the physical and mental symptoms which so often herald the onset of an addictive pattern of drinking.

Psychiatric consultation is an essential part of the therapeutic programme. Even where characteristics of personality have not contributed specifically to the process of the illness, the alcoholic is likely to be in situational and emotional difficulties which need to be resolved in order to achieve contented abstinence. The special skills **of** the psychiatrist are also frequently necessary if the patient's new sobriety is to be maintained. **Consequently the programme of treatment should be drawn up in consultation with a psychiatrist. In the services envisaged by the Commission, this consultation could**

readily be supplied by the psychiatrists working in the out-patient clinics referred to in paragraph 73.

The number of general practitioners informed about and experienced in treating alcoholism is, unfortunately, quite small. **The Commission considers that general practitioners should be trained to have a deeper understanding of alcoholism.** It welcomes the growing attendance of general practitioners at seminars and conferences on alcoholism and considers that regular, officially-sponsored courses should be provided for the family doctors, either in the mental hospitals or at psychiatric units in general hospitals. **The problem of alcoholism is a social as well as a medical one and the Commission recommends that health authority social workers should be made available to provide the necessary follow-up support in the community. Social workers should also participate in the study of environmental factors contributing to alcoholism.**

Alcoholics should be accepted for treatment m district psychiatric clinics whether or not they have been referred by a medical practitioner.

Residential Treatment Facilities

110. Admission to hospital frequently is necessary during the course of treatment. Here again the most important single factor in successful treatment is the personal influence of the doctor. Alcoholic patients require intensive psychotherapy and a particularly close doctor-patient relationship not usually found in general hospitals. The process of treatment frequently involves the discussion of intimate problems; the training and experience of the psychiatrist equips him admirably to gain the patient's confidence, an essential feature for frank discussion. **These considerations led the Commission to decide that residential treatment facilities for alcoholic patients should be provided in a psychiatric setting.** Existing residential facilities in Ireland are organised mainly on this basis. Most alcoholic patients are treated in district or private mental hospitals and the treatment of alcoholics in general hospitals is confined usually to the treatment of physical illness incidental to the alcoholic disease.

A few alcoholics may require long-term care, with a gradual return to freedom and responsibilities of life outside hospital, but most require treatment on a short-term basis only. **The Commission recommends that the residential facilities should be provided in conjunction with short-term psychiatric units. It also recommends that all alcoholic patients in any one hospital should be concentrated in a particular, self-contained section, and should not be dispersed through a number of sections, mixed with other categories of patients.** The establishment of alcoholic units on these lines would facilitate the group psychotherapy which is such **an** important feature of the treatment process. Moreover, the close association of alcoholic patients in such **a** setting encourages them more quickly to under-

stand their illness, to help each other, and to collaborate with Alcoholics Anonymous. All these factors are conducive to earlier discharges.

Specialist staff is necessary to cater for alcoholics. In view of this fact and of the relatively small number of alcoholics needing residential treatment the Commission considers that alcoholic units in three or four regional centres would meet the country's needs. **In addition to centres in Dublin the Commission recommends that units should be provided at Cork and at Galway.**

Role of Voluntary Agencies

111. There are many voluntary agencies in Ireland which are concerned with the prevention of alcoholism and the rehabilitation of the alcoholic. The work of societies such as the Pioneer Total Abstinence Association, the Father Mathew Total Abstinence Association and the Church of Ireland Temperance Society is well known. There are two agencies to which the Commission wishes to make particular reference in this report—Alcoholics Anonymous, because of the importance of its role in helping the alcoholic proper to overcome his difficulties, and the National Council on Alcoholism in Ireland because of what it can do to improve community attitudes towards alcoholism.

Alcoholics Anonymous is an association of people who have in common the fact that they are alcoholics and wish to remain abstinent. The rules of the organisation are sound and, although non-sectarian, A.A. relies on the help which may be obtained from spiritual sources. It is immeasurably valuable in providing a supportive and enjoyable social life for the abstinent alcoholic. The movement is worldwide and has proved its efficacy many times over. The first European A.A. group was established in Dublin nearly 20 years ago and members of the Irish groups have continued to cooperate closely and conscientiously with the psychiatrists in the rehabilitation of fellow alcoholics. **The Commission recommends that all alcoholics should be advised of die benefits which can accrue from membership of the movement.**

Most countries now have organisations specially formed to spread an enlightened attitude towards alcoholism. The Commission welcomes and endorses the recent formation of the National Council on Alcoholism in Ireland. Broadly speaking, the aims of the Council are to educate the public about alcoholism as **a** disease and the needs of alcoholics, to secure improvements in facilities for diagnosis and treatment and to promote research. It proposes to encourage an enhghtened attitude towards alcoholism by using the mass media of communication, press, radio, and television, and by setting up information bureaux in **a** number of centres. Local lectures will be promoted and instruction provided for clergy, teachers and other key members of the community. The Commission visualises that this Council will serve an important preventive and advisory function by spreading knowledge on the dangers of excessive and indis-

criminate drinking, on the patterns of drinking which tend to lead to alcoholism, on the stages through which an alcoholic passes from social drinking to alcoholism, on the types of persons who are prone to alcoholism and on the sources from which help can be obtained when it is required. The activities of the Council could be of particular benefit to the younger age groups.

Research

112. The provision of the services outlined in this section, together with the growth of more enlightened attitudes in the community, is likely to encourage greater numbers of alcoholics and excessive drinkers to present themselves for treatment and to seek it at an early stage. Sample surveys, both of Irish drinking patterns and of the probable prevalence of alcoholism would be of great value in assessing the extent of the problem created by the abuse of alcohol. The Commission recommends that such surveys should be undertaken through co-operation between the Medico-Social Research Board, the Medical Research Council, the National Council on Alcoholism and other interested voluntary bodies. As studies in other countries clearly show that there is a considerable loss in output through alcoholism and problem drinking, some financial support might reasonably be expected from industrial firms but the Commission considers that a reasonable proportion of the cost of surveys should be borne by the State.

(e) DRUG ADDICTS

General

113. Concepts and definitions of drug addiction vary widely and depend largely upon social attitudes and tolerance factors in the community concerned. In recent times the term "addiction" has been applied particularly to the abuse of narcotics such as pethidine, morphia, marijuana, heroin, opium and cocaine; abuse of other drugs of the pep-pill type, such as drinamyl, preludin and dexedrine, has been referred to as "habituation". As some confusion arose in the application of these terms, a World Health Organisation Expert Committee on Addiction-Producing Drugs has recommended that the term "drug dependence" be used to describe abuse of habit-forming drugs.

Under the Mental Treatment Acts 1945-1961 a drug addict means a person who—

(a) by reason of his addiction to drugs is either dangerous to himself or others or incapable of managing himself or his affairs or of ordinary proper conduct; or

(b) by reason of his addiction to drugs is in serious danger of mental disorder.

The Commission accepts that this definition suitably covers most addicts, but there is a less serious form of addiction which is not covered by the definition. This usually arises when habit-forming drugs have to be given in the treatment of illness. Even though in these cases stability can be maintained on small doses obtained legally, the persons concerned would also benefit from treatment for their addiction although this is unlikely to warrant compulsory measures.

Addiction to drugs arises in a number of ways but, in our society, is most likely to arise in one of the following ways:—

(1) from ease of access to sedative type drugs by professional staff in hospitals, etc.,

(2) from the use of drugs of the pep-pill type by young people and

(3) from the growing use of pain-killing drugs by the general public.

On the 31st March, 1963, out of a total of 19,829 patients in mental hospitals only 16 were being treated for drug addiction. Having regard to the very small number of addicts being treated and the apparent absence of any illicit trade in narcotics, the Commission croes not consider that drug addiction is an extensive problem in Ireland at present. However, in recent years, there has been a remarkable growth of addiction in other countries which, in the past, because of contiguity and the ebb and flow of emigrant workers, have tended to influence the pattern of social behaviour in Ireland. **Consequently the Commission considers that drug addiction could reach serious proportions in this country unless a constant effort is maintained to prevent the abuse of habit-forming drugs.**

Control of the Use of Drugs

114. Ireland's very fortunate position in relation to drug addiction is probably due, to a considerable extent, to the Dangerous Drugs Act, 1934, which imposes controls on the import, export, manufacture, sale, possession and use of certain drugs. The principal ones so controlled are raw and medicinal opium, coca leaves, indian hemp, codeine and dionin and their respective salts, morphine and its salts, heroin, cocaine and its preparations, ecgonine and its preparations and pethidine. From time to time additional drugs are recommended internationally for control and the Commission understands that the necessity to bring these additional drugs under control in Ireland is regularly examined.

The abuse of drugs of the sedative, tranquilliser, euphoriant and stimulating types has also come under notice in recent years. In 1954 the retail of barbiturates to the public was restricted to sale on prescription only, and controls, designed to prevent the abuse of prescriptions by frequent presentation or by presentation to different dispensers, were also imposed. An amphetamine type drug—phen-

metrazine—was controlled by Regulations made in 1962. Regulations made in 1963 controlled **a** wide range of similar preparations and confined sale to the public on prescription only.

All of these measures are welcomed by the Commission and it recommends that constant vigilance be maintained to ensure that if any defects are found in the regulations, they should be rectified at the earliest possible date. In this connection the Commission is glad to note from the recent White Paper on " The Health Services and their Further Development" that the Minister for Health proposes to make new regulations which will provide a comprehensive modern code of drug control and that the Health Acts will be amended to impose further controls on the possession of drugs of the pep-pill type.

Treatment Requirements

115. Frequently some degree of compulsion is required before a drug addict can be persuaded to accept treatment for his condition, and as treatment tends to be prolonged, compulsory measures are often necessary to ensure that treatment is continued.

Some aspects of treatment, particularly continuation treatment, are undertaken by general practitioners in the community, but the more intensive aspects are usually undertaken in a hospital. Owing to the small number of cases arising in Ireland and the special nature of the techniques used, it appears unlikely that the treatment of drug addiction could be successfully organised otherwise than in hospital; as very specialised skills are required which would not be available in every psychiatric hospital, it follows that treatment facilities must be centralised. **In the Commission's view a single residential unit should be established to cater for the needs of the whole country. The Commission recommends that such a unit should be established in a psychiatric hospital in Dublin. Despite the long-term nature of the treatment involved, the Commission considers that its intensive nature makes it desirable that such a unit should be associated with a hospital for the short-term treatment of psychiatric patients.** A somewhat higher degree of security than is usual in this type of centre would be necessary, but by careful selection of the particular hospital, and by careful location of the unit, this could be provided without conflicting with the "open door " policy of the hospital proper.

There are many aspects of the problem of drug addiction and its treatment on which present knowledge is at best meagre. The concentration of treatment resources in a single specialist unit should do much to increase the extent of informed opinion at professional level in Ireland. One point brought to the Commission's attention was the growing practice of issuing sleeping pills indiscriminately to patients in general hospitals. It is possible that this practice could induce addiction in susceptible patients. Channelling all addicts through a single unit should give the staff an excellent opportunity to investigate possible causative factors of this nature.

Patients' family doctors should be fully informed of the result of treatment given in the hospital, as they will have to continue treatment when the patient returns to the community and, probably also, have to organise any supportive community services which may be necessary for particular patients.

(f) EPILEPTICS

General

116. Epilepsy is a common form of illness. Accurate statistics of its prevalence are very difficult to obtain, but it is generally accepted that it affects approximately .5 per cent of the population. Of those affected many have only occasional attacks and may display symptoms for a short period only, but others are affected, in varying degrees, throughout their lives. Epilepsy occurs in many forms of mental illness, but all epileptics are not mentally ill. The Commission was concerned primarily with the relatively small proportion of epileptics who display psychiatric symptoms, but found it necessary, in assessing the needs of these patients, to advert to the whole problem of epilepsy. The facilities for its diagnosis and treatment outside mental hospitals are meagre. Some epileptics who are not mentally ill but who fail to obtain, or to respond to, treatment develop anti-social tendencies. These persons frequently are admitted to psychiatric hospitals because facilities are not available otherwise for them, or because their anti-social behaviour makes it difficult to provide effective treatment elsewhere. In recent years considerable progress has been made in the control of epilepsy, particularly if it is treated at an early stage. If more facilities were available outside mental hospitals the numbers which have to be admitted would be less and the disabilities of epileptics living in the community would be reduced considerably. As more than one-third of epileptics have their first convulsion before the age of ten, epilepsy is an important illness of childhood. The avoidance of perinatal infections, birth injuries and accidents producing head injuries should contribute to some extent towards the prevention of epilepsy.

The Commission considers that the problem of epilepsy in the country is in need of examination. In particular, it recommends that diagnostic centres, as outlined in the following paragraph, should be provided.

Diagnostic Centres

117. Experience in other countries clearly shows that adequate treatment of epilepsy necessitates a very careful and detailed diagnosis. Many specialists such as neuro-surgeons, neurologists, ophthalmologists, oto-rhino-laryngologists, paediatricians, psychiatrists and others may be involved in making such a diagnosis. Detailed history-taking and a full physical examination form the basis of the

diagnosis. Diagnostic aids include laboratory tests, radiographic examinations, electroencephalography, an assessment of the patient's psychological capacities and disorders and a survey of his background to determine to what extent it may contribute to his illness. Even taking all forms of epilepsy into account, it is unlikely that it would be necessary to provide fully equipped diagnostic facilities in every county. Prima facie, it appears to the Commission that three fully equipped regional diagnostic units would serve the country as a whole. Dublin, Cork and Galway are probably the most suitable centres because of their accessibility, the presence of teaching hospitals and the availability of some of the laboratory facilities required. Facilities for electroencephalography are essential in all units. The diagnosis may require some days to complete and accordingly a number of short-stay beds should be available to each unit. The majority of the patients are non-psychiatric and accordingly the centres could be located most suitably in general hospitals. The diagnostic units should provide expert advice for doctors dealing with epileptics in the community.

Residential Treatment

118. A number of epileptics require residential treatment—some on a long-term basis and others for short periods during psychotic episodes or bouts of disturbed behaviour. Traditionally the epileptic has been regarded as a patient who required a very settled regime with special emphasis on severe restrictions and avoidance of excesses of all kinds whether in food, work, recreation or excitement. Indeed, because of this reputation, the epileptic always was regarded as potentially aggressive and even in psychiatric hospitals was nursed with apprehension under strict custodial conditions. This, of course, engendered in the patient an attitude of frustration and suspicion and served to delay or prevent his discharge. **The Commission wishes to stress that where residential treatment is provided the aim should be to integrate the patient as far as possible into the life of die community within the hospital and to prepare him for eventual return to the general community outside.**

The Commission was pleased to learn that, in a number of district mental hospitals, restrictive measures formerly applied to epileptics had been discontinued and, that with changed attitudes on the part of staff, a marked improvement occurred in the behaviour of epileptics and their fits became less frequent. Improved nurse-patient relationships, the maximum use of all forms of occupation, including industrial therapy and varied recreational activities, and the encouragement of positive social contacts should serve to bring about the eventual rehabilitation of a significant number of those epileptics for whom, formerly, there was little alternative to long-term custodial care.

Returns furnished to the Commission by the hospital authorities indicated that on 31st December, 1961, 1,287 epileptic patients were accommodated in psychiatric hospitals throughout the country. The

provision of diagnostic centres and of improved community facilities will probably reduce this total, but the Commission is satisfied that a significant number will still require residential facilities. The Commission considered whether these cases should be concentrated in regional units. It was satisfied, however, that the necessary treatment can be successfully undertaken in ordinary psychiatric hospitals and it saw little merit in recommending the organisation of special regional units for mentally-ill epileptics. The use of local hospital facilities has, of course, the great advantage that the patients retain close contact with their friends and relatives and this should serve to facilitate their early return to the community.

(g) PERSONS IN CUSTODY

General

119. The Commission is precluded by its terms of reference from considering the legislation dealing with " criminal lunatics ". It finds it necessary, however, to refer to this legislation in dealing with the psychiatric services required for " criminal lunatics " and for persons, other than " criminal lunatics ", who are detained in prisons.

Definition

120. " Criminal lunatic " is a legal term applicable to any person who, while in custody, has been certified to be insane in any of the following circumstances:

(a) while on remand or awaiting trial;

(b) while undergoing sentence either in a local or convict prison, in St. Patrick's Institution or in an Army Detention Barracks;

(c) while awaiting the pleasure of the Government having been found insane by a jury on arraignment; or

(d) while awaiting the pleasure of the Government having been found " guilty but insane " by a jury.

There is another class of patients who are legally regarded as criminal lunatics. They are ex-soldiers who, on discharge from the British army, were so classified under the provisions of the Army Act, 1881. There have been no additions to this class since the foundation of the State.

It will be seen that the term applies to persons who have never been tried and may never have committed a crime. Others may have committed offences of a very minor nature. The Commission regards " criminal lunatic " as a most unsuitable term and one which is completely inconsistent with contemporary psychiatric concepts. Hereafter in this section of the report the Commission refers to this class of patients as " custody patients ".

Historical Note

121. The first effectual provision for the lunatic poor of the whole country was made by the Lunacy (Ireland) Act, 1821. Under that statute most of the district asylums (now mental hospitals) were erected. The final sections of the Act provided that persons acquitted of offences on the grounds of insanity and persons found insane on indictment were to be detained in the asylums when they were provided. An Act of 1838 permitted the sending to the asylums of persons under sentence of imprisonment and persons committed for trial who were certified to be insane. The position until 1850 was that all these classes of custody patients were maintained in the district asylums at the expense of the local authority. In 1845, a Committee of the House of Lords recommended the establishment of a separate asylum for custody patients and the Central Asylum at Dundrum (now called the Central Mental Hospital) was erected and was opened in 1850. The preamble to the Act of 1845, which provided for the erection of this hospital, stated that it was expedient that "One Central Asylum in or near the City of Dublin should be provided for the Custody and Care of Criminal Lunatics ". The Act of 1845 provided that as soon as the new building was ready, all custody patients could be removed to it on the order of the Lord Lieutenant. This Act is still in force, although Parliament subsequently recognised the fact that all custody patients were not being maintained in the " central asylum ", by providing that the expenses in relation to custody patients confined in district mental hospitals would be met out of voted monies. Apparently, after the Central Mental Hospital was opened, the number of custody patients removable exceeded the available accommodation and, notwithstanding the clear intentions of the law which transferred from the local authorities to the central government the duty of maintaining such patients, a selection of cases had to be made and this continued to be the rule. The hospital was used mainly for persons who had committed heinous offences and for persons who exhibited violent and dangerous symptoms whether their offences were grave or not. It is clear that this practice did not fulfil the intention of the law, which was that custody patients should be dissociated from others. The primary object in providing the " central asylum " was not the treatment and cure of custody patients, but the segregation of persons who had committed offences, or were charged with offences, from other patients. The object was never attained because the State did not make the provision which was necessary.

Present Legal Provisions

122. The legal provisions now in force may be summarised briefly as follows :—

(a) *Admission and Detention Procedures*

Persons in custody who are found to be mentally ill may be admitted either to a district mental hospital or to the Central Mental Hospital on the order of the Minister for Justice. This order obliges the Resident Medical Superintendent to keep the

patient in question " in confinement until further order of the Minister for Justice." Such persons may also be transferred by the Minister for Justice—

(a) from the Central Mental Hospital to a district mental hospital and

(b) from a district mental hospital to the Central Mental Hospital or another district mental hospital.

The authorities for these procedures are contained in Acts of 1821 (1 and 2 Geo. IV. cap. 33), 1838 (1 Vic. cap. 27), 1845 (8 and 9 Vic. cap. 107), 1875 (38 and 39 Vic. cap. 67), 1883 (46 and 47 Vic. cap. 38) and in the Criminal Justice Act, 1960 (No. 27 of 1960).

There is a slight variation in the case of any person in the armed forces imprisoned or undergoing detention by virtue of the Defence Act, 1954. If such a person becomes of unsound mind, any Minister of State may order his removal to a mental hospital, where he remains for the unexpired portion of the term of imprisonment or detention.

(b) *Discharge Procedures*

Under Section 3 of the Criminal Justice Act, 1960, the Minister for Justice is empowered to release temporarily any custody patient who, in the opinion of the person in charge of the hospital, is not dangerous to himself or others. Apart from this temporary release process, the discharge of custody patients is regulated as follows :—

Persons " on remand," or awaiting the " Government's pleasure " having been found insane by a jury on arraignment, or awaiting the "Government's pleasure", having been found guilty but insane by a jury, stay in the district mental hospital or the Central Mental Hospital until they are certified as having recovered. They may then be returned to custody or discharged by the Minister for Justice. (In the case of persons who have been accused of murder or who have been found guilty of murder but insane, the matter is referred to the Government by the Minister for Justice before conditional or absolute discharge is authorised).

Persons awaiting trial stay in the mental hospital only until the "Assizes, Sessions or Commission at which such person should be brought to trial". The person is then usually arraigned, found unfit to plead and dealt with as in the previous paragraph.

Persons undergoing sentence remain in the mental hospital if they continue to be of unsound mind until their sentences expire when they are dealt with as ordinary patients. If they recover before their sentences expire they are returned to prison. Patients in the Central Mental Hospital who have been sentenced are usually transferred

to the appropriate district mental hospital by the Minister for Justice if they are still of unsound mind on completion of sentence.

A member of the armed forces who is certified to have recovered before the expiry of his sentence may be removed to any prison or detention barracks on the order of a Minister for State.

Numbers and Types of Custody Patients

123. Generally speaking, persons who have committed heinous offences or persons who exhibit violent and dangerous symptoms, whether their offences were grave or not, are accommodated in the Central Mental Hospital. This pattern is by no means clear-cut, however, as will be seen from the following table which illustrates the position in Ireland on 31st December, 1965—

	Number of Custody patients 31/12/1965	
	In Central Mental Hospital	In District Mental Hospitals
1. Murder	35	8
2. Violent Assault	8	1
3. Common Assault	16	7
4. Rape or attempt or indecent assault	—	6
5. Arson.	3	10
6. Burglary and Housebreaking..	4	1
7. Theft and Larceny	—	4
8. Other Offences	36	58
TOTAL ..	102	95

Cost of Maintaining Custody Patients

124. The cost of custody patients in district mental hospitals is borne by the Department of Justice, which pays the mental hospital authorities the average cost of maintenance, including loan charges. The main costs in connection with the Central Mental Hospital are borne by a special Vote administered by the Minister for Health, but appreciable expenditure on maintenance and running expenses falls on the Vote for Public Works and Buildings. (The cost of maintenance of cases sent to the Central Mental Hospital by Order of the Minister for Health under Section 207 of the Mental Treatment Acts, 1945-1961, is met out of the Vote for the Central Mental Hospital—see paragraph 128. Persons committed to district mental hospitals under the provisions of Section 91 of the Army Act, 1881, are also legally classified as criminal lunatics under the definition in section 6 of the Act of 1901 and their maintenance falls on the Exchequer under section 3 of that Act.)

Position in other Countries

125. The following extract from a survey of existing legislation

published by W.H.O. in 1955* illustrates the position in other countries:—

> " Provision is also made in most countries for the examination of prisoners suspected to be mentally ill or defective and, if so found, for their committal to an appropriate institution. It is usually the medical officer of the prison or a forensic psychiatrist who conducts the examination. Commitment may be made to a general hospital, to a psychiatric hospital (Denmark) to observation centres in certain prisons (England and Wales, Germany, Sweden) or to a special department of hospital for the criminally insane (Brazil). If the term of sentence expires before cure, a patient is usually further detained, although he may be transferred to a general mental hospital. If, however, recovery occurs before expiry of sentence, the person may be returned to prison. While in some countries such patients may be discharged from mental hospitals by the same authority as discharges other mental patients, in others they may only be discharged with the permission of the authority that ordered their admission ".

Need for Special Unit

126. An Expert Committee of the World Health Organisation (Technical Report Series No. 98) stated, in 1954, that "it is as undesirable for judicial authorities to have power to commit convicted prisoners to civil mental hospitals by reason of mental illness as it would be for them to have power to commit tuberculosis prisoners to civil general tuberculosis hospitals; to do so is to stigmatise the civil hospital and create practical difficulties in the treatment of patients. The penal authorities should ensure that a mental hospital exists within the penal service to treat criminal cases. If for a particular individual this is considered either unnecessary or undesirable, the case could be dealt with by probation, or a suspended sentence, to enable the individual to be admitted to a civil mental hospital in the normal manner. This point is emphasised since, as long as civil mental hospitals contain patients committed to them by judicial order, so long will they be stigmatised in the public eye, and the situation is made even worse if they contain patients who cannot be discharged on recovery by the Medical Superintendent since they are committed there by a judicial order for criminal acts."

The report goes on to emphasise that, while it should be possible to transfer mental patients easily from prisons to mental hospitals, the mental hospitals should not be asked to undertake custodial care of dangerous criminals. These should, in the opinion of the Expert Committee, be cared for in special establishments for criminals.

The Commission agrees in principle with the views of the Expert Committee. However, it does not regard it as essential in this country that all custody patients should be sent to a special hospital; or if

•International Digest of Health Legislation, 1955. Vol. 6, No. 1.

sent there, that they should be retained in the special hospital until they have been certified to have recovered or until their sentences have expired. It must be remembered that some patients in this category have not been tried and, therefore, have not been proved guilty of any crime; some have been proved guilty of, or have been suspected of, crimes of a minor nature; some have been proved guilty of, or have been suspected of heinous crimes; some have remained as custody patients far beyond the time they would have remained in jail had they been tried and sentenced to a term of imprisonment; some suffer from severe forms of mental illness—others from relatively mild forms. These patients, therefore, do not form a homogeneous group. Many of them are people whose presence would not stigmatise a district mental hospital to any appreciable extent. All custody patients are not dangerous. This is evidenced by the fact that the Minister for Justice can and does consent to the temporary release of such patients. It is clear that some custody patients can be cared for in district mental hospitals without detriment to the hospital and without harmful effects to their psychiatric treatment. **The Commission is of opinion, however, that a district mental hospital, in most** cases, **is not a suitable place for such a patient if, for reasons other than the type and degree of his mental illness, it is expedient that he should be kept in confinement.** Such a requirement may create very serious problems. If the hospital is completely open, as some are nowdays, there is no place in which to confine him. If suitable provision is not made for his confinement, the mental hospital authority will be in a very invidious position should he escape and commit a serious crime. If a ward has to be relocked to accommodate him, it may result in injustice to other patients. In hospitals which are not completely open the only place to keep him is in the locked wards. These wards usually contain patients suffering from grave forms of mental illness, and, from the psychiatric point of view, they may be most unsuitable for his treatment. **The Commission recommends therefore, that the Central Mental Hospital at Dundrum should be retained as a special hospital for certain patients in this category.** As detailed in later paragraphs, it is desirable that use should be made of the Central Mental Hospital to provide, in addition, care and treatment for other types of patients. It will require more facilities and staff than other mental hospitals. It is undesirable, therefore, that it should be used for the care and treatment of custody patients who could be provided for suitably in district mental hospitals. The Commission considers that the decision whether a particular patient should be sent to, or should be retained in, the Central Mental Hospital should be determined on the merits of each case, but the main factors which should be taken into account are whether:—

(a) it is possible, without detriment to his psychiatric treatment or the psychiatric treatment of other patients, to provide in the appropriate district mental hospital the degree of confinement regarded as expedient for non-medical reasons;

(b) his presence in the appropriate district mental hospital would unduly stigmatise the hospital;
(c) there are facilities in the Central Mental Hospital for his psychiatric care which would not be available at the appropriate district mental hospital.

Prisoners other than Custody Patients

127. As outlined in the preceding paragraphs, psychiatric treatment is made available for prisoners and detainees who are certified to be insane or of unsound mind. However, there are many persons sentenced to prison or detention who are not obviously mentally ill but who could benefit substantially from psychiatric attention. The services available for these are in need of improvement. It is probable that the prison population constitutes a very high risk group from the point of view of psychiatric illness, as emotional disturbance is a prominent causative factor in persons who come into conflict with the law and imprisonment naturally creates its own stress factors which, if unrecognised and uncorrected, can have a very detrimental effect upon the prisoner's mental health.

Under modern concepts of penology one **of** the prime aims of imprisonment or detention is not so much to exact payment from offenders for their crimes as to expose them to influences which will develop their characters and equip them to accept the full responsibilities of citizenship on return to the community. It is now generally accepted that psychiatry has an important contribution to make in this field. The Commission considers that psychiatric services should be available in all prisons, for the detection and treatment of stress factors, emotional disturbance and other psychiatric disorders. As with other types of patients, a team approach will usually be necessary; the services of a psychiatrist, a psychologist and social worker will normally be required and the services of other workers may sometimes be necessary. Prisons are few and relatively small and serve large areas, so that it would be difficult for those in charge to organise their own psychiatric services. It would probably be preferable that they should make use of the services provided for other classes. **The Commission recommends that the authorities of prisons and detention centres should make arrangements with the appropriate health authorities for the provision of psychiatric services for prisoners. The Commission recommends that prison staff and staff in training should be given appropriate instruction in the principles of mental hygiene.** The development of the Central Mental Hospital on the lines suggested in paragraph 126 would make available for this purpose staff with a particular interest in forensic psychiatry and penology.

(h) HOMICIDAL AND VERY VIOLENT PATIENTS

General

128. Under Section 207 of the Mental Treatment Act, 1945, a patient in a district mental hospital may be charged with an indictable

offence, before a Justice of the District Court sitting in such district mental hospital. If, on the basis of the evidence given, the Justice is of opinion that there is prima facie evidence that the person committed the offence and would, if placed on trial, be unfit to plead, the Justice may by order certify that the person is suitable for transfer to the Central Mental Hospital. The Inspector of Mental Hospitals then examines the patient, who is kept, meanwhile, in the district mental hospital concerned, and, after consideration of the report of the Inspector, the Minister for Health, may, if he so thinks fit, by order direct and authorise the transfer of the person to the Central Mental Hospital. The Minister may also order that such person be sent back to the district mental hospital from which he was transferred. When a person sent to the Central Mental Hospital under this Section is certified by the Resident Physician and Governor of the hospital and the Inspector of Mental Hospitals to have ceased to be of unsound mind the person concerned must be discharged.

Need for Change

129. The Commission considers that there is a weakness in the provisions in Section 207 in that a person cannot be transferred to the Central Mental Hospital until he has committed an indictable offence. Some persons may be known to be very violent or homicidal, but if they are carefully watched they may be prevented from committing indictable offences. This may involve the continuous assignment of a nurse to an individual patient and may necessitate the creation of security measures which would otherwise not be required. The number of persons involved is small, but their presence in a district mental hospital can create serious difficulties and can have adverse effects on the hospital and on other patients. **The Commission considers that there should be provision for the transfer of such patients to the Central Mental Hospital and that such patients and patients at present dealt with under Section 207 should be transferred as a result of medical certification, rather than as a result of judicial procedure.** Not all violent or homicidal patients need to be transferred from district mental hospitals—there are various degrees of violence and both violent and homicidal tendencies may be transient phases. The decision to transfer a patient from a district mental hospital to the Central Mental Hospital is a serious one and it is essential that some formal procedure should be followed so that the interests of the patient, of the district mental hospital and of the Central Mental Hospital are all given full consideration. **The Commission recommends the following procedure**:—

(a) Where the psychiatrist in charge of a district mental hospital is satisfied that the condition of a patient detained in the hospital **is** such as to justify his transfer to the Central Mental Hospital he may apply to the Minister for Health for an order directing his transfer. Before forwarding the application to the Minister the psychiatrist in charge shall

notify the patient and the person who applied to have him admitted of his intention so to apply to the Minister and shall advise them that they may, if they so desire, make representations to the Minister on the matter.

(b) The Minister shall require the Inspector of Mental Hospitals to examine the patient and, after such consultation with the psychiatrist in charge and with the Governor of the Central Mental Hospital as he considers necessary, to make a report on the matter.

(c) On consideration of the application, the report of the Inspector of Mental Hospitals and any representations received from the patient or the applicant for the reception order, the Minister may direct the transfer of the patient to the Central Mental Hospital.

(d) On consideration of a report from the Governor of the Central Mental Hospital and from the Inspector of Mental Hospitals, the Minister may direct that a patient transferred to the Central Mental Hospital under these provisions should be sent back to the district mental hospital.

(j) PSYCHOPATHS

General

130. Psychopaths are people with an abnormality of personality, particularly evident in the sphere of conduct, and usually recognisable from an early age. They deviate from the normal in degree rather than in kind. They are distinguished from the mentally handicapped by the fact that their deficiencies are emotional and volitional rather than principally intellectual, and from the neurotic because they cause society to suffer. The inability of psychopaths to conform to the rules and customs of society was pointed out by a Bristol physician,* J. C. Prichard, in 1835, in his well-known description of " moral insanity ". This lack of social conscience can manifest itself in many different ways.

Psychopaths do not appear abnormal on first acquaintance. They are in full possession of the ordinary mental faculties, are not necessarily stupid, and may indeed be of superior intelligence. Superficially, their emotions may appear to be quite normal. They may be witty and show outstanding personal charm, but this may be merely a facade for cold-blooded ruthlessness. Psychopathy can appear in relatively innocuous forms in tramps, layabouts and other such non-assertive goal-less persons who are utterly dependent on charity for a living. It causes greater nuisance to society when it appears in forms such as thieving, swindling, sexual perversion, drug addiction and alcoholism. There are also more dangerous forms

*A Treatise on Insanity, London, 1835.

typified by the person who has an explosive temper or is violently aggressive and may commit murder on little, if any, apparent provocation.

In their work record, psychopaths consistently show their inability to follow the patterns of society. They drift from job to job, sometimes being dismissed for insubordination but as often stopping work because they become restless and bored. They are aware that they are misfits but are not disturbed by this and thus have no incentive to do anything about it. Their anti-social or amoral tendencies frequently lead them into conflict with the law and many are found in the ranks of criminals. But the psychopathic criminal is impulsive, irresponsible and emotionally abnormal, not only in connection with his crimes, but also in other aspects of his life.

Psychopathy probably results from a number of causes, hereditary, constitutional and environmental. Treatment is always difficult. Nevertheless, some psychopaths respond to special methods of training and education, including group therapy; and there is probably a tendency towards improvement in social adaptation with increasing age. In some cases the psychopath may eventually find a place for himself, even though it may be on the fringe of society.

Treatment

131. Specialised treatment for psychopathy has not yet developed in Ireland. Effective treatment cannot be organised on a community basis because patients generally are slow to seek treatment on their own initiative or to be guided by the advice of friends or relatives who may be anxious to help. Consequently, treatment must be provided largely in residential centres, which are of two kinds:

(a) Centres for non-aggressive psychopaths, who come to the notice of the authorities because of non-violent crime, drug addiction, alcoholism, sexual deviation, or suicidal attempt, or because of a psychotic episode. Some psychopaths of this type will accept in-patient treatment, but with others it will have to be under compulsion, for a period of time, if any worthwhile benefit is to be achieved.

(b) Centres for aggressive psychopaths, who are compulsorily detained because of crimes of violence or behaviour that is potentially harmful to others.

Non-aggressive psychopaths often find themselves a comfortable place in the regimen of a long-stay psychiatric hospital, but if specialist treatment is not available, little can be done for them in such a hospital except to provide them with board and lodgings. The aggressive types are not welcomed in psychiatric hospitals because their behaviour tends to disrupt the treatment programme of other patients and, in any case, the security measures necessary conflict with the open door regimen of the mental hospital.

Experience in other countries shows that worthwhile results can be achieved with both types of psychopath when a suitable milieu

is provided. Treatment is specialised for both types and for the aggressive type varying degrees of security are required. The hospital needs of psychopaths, therefore, cannot be met in all mental hospitals. Specialised units must be developed and, in relation to Ireland, the Commission considers that an organisation on the following lines would be most effective:—

One central unit should be organised to cater primarily for aggressive types. The Commission recommends in paragraph 126 that the Central Mental Hospital, Dundrum, should be retained as a special hospital for certain custody patients and, in paragraph 129, that it should cater also for violent and homicidal patients who create serious difficulties in district mental hospitals, where they have a very adverse effect on other patients. The staffing and hospital milieu suitable for these categories of patient would also be appropriate for psychopaths. **Accordingly, the Commission recommends that a special unit, providing varying degrees of security, should be established in the Central Mental Hospital, Dundrum, to cater for the residential needs of aggressive psychopaths from the country as a whole. About 50 beds would be required.**

This hospital could cater also for some non-aggressive psychopaths and the Commission considers that it should eventually become a research unit for all categories of psychopathic patient.

The transfer of psychopaths between this unit and the long-stay hospitals should be governed by procedures similar to those outlined in paragraph 129.

All non-aggressive psychopaths could not be catered for in one hospital and consequently, as experience of dealing with the problem grows, consideration should be given to the possibility of establishing further regional units specialising in the treatment needs of psychopaths of this kind. Such additional units could be attached to long-stay psychiatric hospitals. Training courses for staff in these units should be provided in the Central Mental Hospital.

(k) PERSONS APPEARING BEFORE THE COURTS

General

132. The Commission considers that, as with children and adolescents, offences by adults may be a symptom of emotional disturbance or other psychiatric disorder. Thus the criminal psychopath may transgress simply because of an impulse which he cannot control; the drunken driver may be a victim of the disease of alcoholism; a murderer may be motivated by delusions of persecution. Practising lawyers and judges should be sufficiently cognisant of the patterns of abnormal behaviour to appreciate their importance in relation to offences against the law and to recognise cases in which psychiatric advice is desirable. **The Commission recommends that the Courts should be in a position to obtain a full psychiatric report in any case where there is any evidence to suggest that mental illness may**

have a bearing on the crime with which a person is charged. It suggests that in appropriate cases consideration should be given to the imposition of a suspensory sentence, on condition that the accused enters into recognisances to avail himself of such psychiatric treatment as may be stipulated by the Court.

(1) SEXUAL DEVIATES

General

133. In recent years, the term "sexual deviate" has to a large extent supplanted the older term " sexual pervert," largely perhaps because of the implied reproach in the term " pervert," but also because of developing insight into the causation of some forms of behaviour now called deviant. Sexual deviates are not necessarily mentally ill, but they are a vulnerable group who may be in need of help. In the past, the only measures adopted by society were punitive. In recent years, there has been a considerable change for the better in public attitudes as more insight is gained into the causes of, and the possibility of altering, deviant behaviour. It would be, however, an exaggeration to claim that the causation of such behaviour is fully understood or that much progress has been made in its treatment. Although this is so, the sexual deviate needs whatever help he can obtain from medical science. Apart from the fact that it may be contrary to the law of the land, deviant behaviour can result in considerable unhappiness. The deviate is usually aware that he or she is different and this often causes considerable stress and worry; deviant behaviour frequently results in the break-up of families, with resultant stress to children and other dependants.

Treatment

134. As knowledge advances more methods of treatment probably will be devised, but, at present, treatment consists largely of counselling aimed at acquainting the patient with the social consequences of his deviation and helping him voluntarily to abandon his deviant behaviour. Counselling of this nature can be very effective, particularly at the adolescent stage. **The Commission recommends that counselling services should be available at the local psychiatric clinics. The Commission also recommends that parents, teachers, general practitioners and other persons who may be aware of individuals whose deviant behaviour would warrant psychiatric intervention should endeavour to ensure that the persons concerned attend at the local psychiatric clinics for appropriate advice. The Courts also should have psychiatric and psychological reports available to them when dealing with sexual deviates. The Commission considers mat psychiatric treatment is likely to be more effective for sexual deviates than imprisonment, which is seldom successful in changing the deviate's behaviour. Imprisonment may, of course, be necessary in some cases to protect society from particular offenders.**

CHAPTER 7

PREVENTION AND RESEARCH

(A) PREVENTION

General

135. In mental health, as in other health fields, it is necessary to distinguish prevention at different levels—primary, secondary and tertiary. Primary prevention aims at eliminating the factors which induce illness. Secondary prevention aims at discovering illness as early as possible so that prompt and effective treatment can be given at a stage when the illness is most susceptible to treatment, so that its progress is prevented. Tertiary prevention aims at preventing or minimising the after-effects and residual disabilities arising from an illness which has developed. It follows from this concept of prevention that all treatment services have a preventive aspect. It is being recognised increasingly that only by concentration on these aspects and by the institution of specific preventive measures can the enormous impact of mental illness be substantially reduced.

(a) *Primary Prevention*

General

136. The causes of mental illness are in many cases unknown. Many causative factors are recognised, but exactly how and why they operate are only imperfectly understood. In the present state of our knowledge, therefore, there is no ready, obvious, or sure means of preventing mental illness and methods similar to vaccination or immunisation for infectious or contagious diseases are unknown. There are, however, spheres where it is accepted that primary prevention is possible. Brain damage (arising during pregnancy and childbirth or caused by industrial, traffic or other accidents), venereal diseases (e.g. syphilis), and certain toxic conditions (e.g. lead poisoning), and nutritional deficiencies (particularly in the elderly) may lead to mental illness. While prevention in these fields is important, the numbers affected are relatively small; the greatest scope for primary prevention probably lies in the field of emotional disturbance. Most authorities now accept that while genetic factors, degenerative changes and toxic conditions are important, the main causative factor in most mental illness is the failure of the personality to cope with the stresses, mainly psychological and social, of everyday life. Stress of various kinds is part of the normal pattern of living and probably is essential to the process of maturation. It would be impossible to prevent stress, even if it were desirable to do so.

Emotional stress, however, if it is unduly severe and prolonged, particularly in the young, may lead to emotional disorder and maladjustment and, eventually, to neurosis or psychosis. It is impracticable to provide services which will ensure that all severe emotional stress will be avoided or which will enable every individual to cope adequately with such stress as does arise, but by general educational and supportive measures and by concentrating on particular groups or individuals it is possible, in many cases, to prevent the development of unduly severe and prolonged stress, or to mitigate its effects.

Education and Integration

137. In Chapter 8 the Commission stresses the importance of education at all levels. In Chapters 4 and 9 it stresses the need for the integration of psychiatry and general medicine. Its recommendations in regard to these matters have an important bearing on primary prevention. Some preventive measures require close liaison between psychiatry and general medicine—others lie outside the field of medicine. The prevention of brain damage, venereal disease, toxic conditions and nutritional deficiences may involve general practitioners and various medical specialists. The prevention of undue and prolonged emotional stress is a field in which help can be provided by parents, relatives and friends, general practitioners, nurses, social workers, public health personnel and key persons in the community, such as clergy and teachers, as well as by psychiatrists, psychologists and other specialised staff. In addition, relief from stress may be provided by general social measures such as housing, relief of unemployment and old age pensions. **The Commission recommends mat in the educational measures suggested emphasis should be laid on the preventive aspects of psychiatry and on the need for community effort in which professional workers in all disciplines will co-operate with one another and with the general public in the prevention of mental illness.**

Children and Adolescents

138. There is little doubt that good family relationships are the basis of sound mental health. The attainment of a desirable degree of mental integration is largely dependent upon a process of successful mental growth and development. The Commission discusses in Chapter 8 the importance of pre-marriage and post-marriage guidance courses. Further help for parents can be provided by counselling services. A word of enlightened advice to parents, from any source, may prevent the development in a child of an emotional upset which would lead ultimately to the need for treatment at **a** district or regional child psychiatric clinic. General practitioners, clergy, public health personnel, teachers and school psychologists have most important roles to play. General practitioners and clergy frequently are in close touch with the home and are in a position therefore to recognise, at an early stage, conditions which may lead to difficulties.

Public health personnel through their visits to the home, Child Welfare Services and School Health Examination Services are in touch with a large number of children and likewise are in a position to recognise possible dangers. Teachers and school psychologists frequently can spot the initial signs of trouble. **The Commission recommends that every effort should be made to inculcate in all those dealing with children and adolescents a sound grasp of the principles of mental health. The Commission also recommends that the district and regional psychiatric clinics should be ready at all times to provide advice in any cases where problems or difficulties arise.**

Youth Organisations

139. While the foundations of mental health must normally be laid in the home, youth organisations, properly conducted, can help considerably in the development of good mental health among their members; they encourage the young to discover and develop their powers of mind and body, to make effective use of their leisure, to direct their energies into healthy pursuits and to prepare themselves for the responsibilities of adult life. The need for clubs has been stressed in paragraph 100. Unfortunately many youth organisations are more concerned with the needs of the club than with the needs of their individual members. Too often the unruly, the ungifted and the unsociable, who can benefit most, are shed silently in the interests of preserving a favourable public image. The needs of the club should never be allowed to transcend the needs of the individual members in this way. To guard against this danger and to ensure that the most effective use is made of the potential of a youth organisation to mould character, the responsible authorities should be fully aware of the principles of mental hygiene. **Accordingly, the Commission recommends that courses in the principles of mental health should be provided for youth leaders and all those concerned with youth organisation.**

Vulnerable Children and Adolescents

140. Emotional disturbance in children and adolescents can arise in any family but some groups are particularly vulnerable e.g.:

(i) Illegitimate children who are deprived of a normal family life.

(ii) Children in homes where the normal family environment **is** absent, owing to factors such as the full-time employment of the mother, employment of the father away from home, death, desertion or imprisonment of a parent, and separation or divorce.

(iii) Children in homes where one or both parents or some other relative is mentally unstable.

(iv) Children in institutions, including hospitals for long-term care.

(v) Children in families where one or both parents are drinking or gambling to excess.

Such children and adolescents should be regarded as " at risk " and the Commission recommends that they should receive special attention—particularly from general practitioners and public health personnel.

Training in Civics

141. The Minister for Education has recently indicated that training in Civics will be added to the curricula for secondary and, vocational schools and that consideration is being given to the possibility of incorporating it in the national school programme. **The Commission recommends that this should be done as it would help to inculcate in young people a greater sense of communal responsibility and appreciation of the fact that the welfare of individual members is the concern of the whole community.**

Career Guidance

142. In many cases the selection of a suitable occupation is a cause of considerable stress to young people and to their parents. In addition, workers often are found to be suffering from stress caused by having chosen occupations for which they are not suited. Vocational assessment and career guidance services have already been developed by a number of schools and private organisations, and the National Organisation for Rehabilitation provides a vocational assessment and placement service for handicapped persons. **The Commission recommends mat the development of vocational assessment and career guidance services should be encouraged in every way.**

Vulnerable Adults

143. The Commission has stressed in paragraph 140 that certain groups of children and adolescents are particularly vulnerable. Persons in these groups may also be vulnerable as adults, particularly if they have suffered severe emotional stress when young. Some adults may be vulnerable in circumstances which produce particular stress e.g. at the menopause, on retirement and in old age, or on the death of a spouse. Persons living alone may suffer from loneliness which is a potent factor in producing mental stress. **The Commission recommends that all health workers should be aware of the factors which produce stress in individuals and that they should pay special attention to those who may be vulnerable. The Commission also recommends that the psychiatric services should be ready at all times to provide advice and counsel for those in need.**

Maternity patients require special consideration as their condition tends **to** intensify psychiatric problems and they are frequently catered for in special hospitals where psychiatrists are not as readily

available as in general hospitals. **To provide for their special needs the Commission recommends that psychiatric clinics or facilities for consultation be provided at all maternity hospitals.** Such services would be invaluable in dealing with problems such as—

(a) the many marital difficulties which come to light when patients attend maternity hospitals;

(b) difficulties which arise in the early months of pregnancy such as rejection of pregnancy and anticipatory difficulties;

(c) puerperal psychosis;

(d) the minor, but relatively common, emotional disturbances seen in post-natal cases.

The Commission considers that these psychiatric clinics should be held in the maternity hospitals, rather than at separate centres, as the difficulties of pregnancy may prevent many women from making a special journey to a separate centre.

Preparation for Retirement

144. The problem of ageing populations is causing concern in most countries. In this country the percentage of persons aged 65 years and over rose from 9.66 in 1936 to 11.18 in 1961 (the date of the last published census). Many people as they grow old suffer from some form of mental impairment or illness. The Commission considers that a considerable amount of this could be prevented if steps were taken to help old people to use to greater advantage the additional years which medical science and improved social conditions have added to their lives. The programme of public education recommended in Chapter 8 will help to do this. A specific form of adult education which the Commission considers would be of considerable help is preparation for retirement. For many people retirement results in a considerable reduction in income, loss of work and occupation, fewer contacts with other people and, frequently, loneliness and a feeling of having no longer a useful role in life. Notwithstanding the dangers inherent in this situation, many people make no preparation for retirement and give little consideration to its implications until it is upon them. By co-operation between employers, Trade Unions and voluntary bodies, much can be done to prepare people for retirement and to teach them how to make best use of the leisure time which retirement will bring. **The Commission recommends that courses of instruction in preparation for retirement should be undertaken by the national voluntary body recommended in paragraph 188.**

(b) *Secondary Prevention*

General

145. **In** general, the further a mental illness is allowed to develop **the** longer will be the period of treatment required. An emotional

upset in a baby may be rectified by an enlightened word of advice to the parents; if the upset is allowed to persist it may require months of treatment in the school years and, if still untreated, possibly years of treatment in later life. Early discovery and prompt and expert treatment are, therefore, the essence of secondary prevention. The services recommended by the Commission should result in early treatment in most cases. **The Commission further recommends that in educational measures emphasis should be laid on the preventive aspects of early treatment and that, in particular, all health personnel should be trained to recognise the early signs of mental illness.**

(c) *Tertiary Prevention*

General

146. The Commission has recommended already a system of community and in-patient services which should provide tertiary prevention by preventing, or minimising, the after-effects of and the residual disabilities arising from mental illness. **It further recommends that, in the training of psychiatric staff, emphasis should be laid on tertiary prevention, so that the rehabilitation of the patient always will be borne in mind.**

(B) RESEARCH

General

147. The magnitude of the problem of mental illness in Ireland will be clear from a study of previous chapters in this Report. About 40 per cent of hospital beds in the country are occupied by persons suffering from mental illness. There is in the community an unknown, but clearly considerable, number of persons suffering from mental illness of some degree. Practically every mentally ill person has an affect on others, so that a very large proportion of the population is affected directly or indirectly by mental illness. Despite this fact, hardly any research is being done into the treatment of mental illness, into the efficacy of different forms of care or into causes and possible methods of prevention. **The Commission regards it as essential that such research should be carried out.** While Ireland can benefit to a considerable extent by research carried out in other countries, there are many particular problems (e.g. the problem of the exceptionally high hospitalisation rate, the problem of late marriages and the effect of the Irish social structure on mental illness) which research in other countries will do little to solve.

Expenditure on Research

148. **In** 1966-67 the estimated net expenditure by health authorities on mental health services amounts to £6,535,000—over 20 per cent

of their estimated expenditure on all health services. If to the health authority expenditure on mental health services there is added the cost of private mental hospitals and homes, other health authority expenditure (e.g. disabled persons' allowances to the mentally ill, services provided by health authority district medical officers, etc.), private expenditure on doctors' fees, drags and medicines, etc., it will be seen that the total expenditure must be well in excess of £7 million per year. This is probably relatively greater than the sum spent in Britain where expenditure on mental, psychoneurotic and personality disorders was estimated to be £100.4 million in 1961. In the U.S.A. medical research expenditure in 1961 amounted to approximately £370 million or approximately 3.6 per cent of expenditure on health. In Britain medical research expenditure amounted in 1961 to approximately £27 million, or about 2.7 per cent of the National Health Service costs. These figures do not give the total research expenditure on illness as there are other forms of research as well as medical research. The Commission appreciates that this country may not be able to spend as much money on research, even proportionally, as larger and wealthier countries. **However, in the light of the foregoing figures and of the many special problems needing attention, the Commission considers that this country would be justified in spending an appreciable amount of money on research into mental illness.**

Nature of Research

149. Research of its very nature is a field where firm guide-lines cannot be laid down. They will have to be determined from time to time in the light of current knowledge and current ideas as to the most fruitful lines of enquiry. They will depend also on the amount of money and the number of skilled research workers available. In psychiatry the possible lines of enquiry are very numerous; in basic research there are investigations of the brain and nervous system, and studies in biochemistry, genetics, physiology and sociology; in applied research there are studies in prevention and in the effect of various forms of care and treatment. Research into mental illness need not be confined to psychiatrists—it can be carried out in fields such as psychology, physiology, anatomy, biochemistry and the social sciences.

The Commission does not regard it as practicable or desirable to suggest die exact form research in mis country should take, but it considers mat a social and medical investigation of the causes of the high hospitalisation rate in this country should be undertaken as soon as possible.

Research Agencies

150. While many agencies may take part in different aspects of research programmes, the Commission considers that responsibility for most scientific research into mental illness in Ireland will fall on one or more of the following five agencies :—

Health Authorities

Health authorities, as the bodies providing the major part of the mental health services, are vitally interested in research. Most health authorities, however, are much too small and have insufficient staff to carry out research, except research of a small and limited nature. **They should be empowered and encouraged to carry out such research projects as are within their competence.** It is essential, however, to ensure that there is not unnecessary duplication of effort and that any research carried out by health authorities is co-ordinated with that of other bodies.

Department of Health

The Minister for Health is the main co-ordinating and supervising authority for the mental health services and is responsible for the payment of more than half of the cost of the total expenditure. He has accordingly a vital interest in all aspects of mental illness, including research. However, it is held sometimes that a Minister of State must necessarily become deeply committed to particular health policies and that there is a danger that research work under the control of a Minister might be channelled along lines which would serve the Minister's executive functions instead of being allowed to develop along the lines most likely to prove useful. Whatever the reason, Government Departments have not in the past accepted responsibility for research. **The Commission sees no reason to suggest any radical alteration in this policy, but it regards it as desirable that the Minister should take an interest in the problem of research and should collect statistical data which would provide guide-lines as to desirable lines of investigation.**

The annual reports of the Department of Health and the Inspector of Mental Hospitals are a valuable source of information for officers operating local health services. Their publication, however, tends to be very much in arrears with the result that the information is made available too late to be of real value. The Commission recommends that every effort should be made to publish these reports as soon as possible after the year to which they relate.

The Universities

Traditionally research has been linked with Universities where it is essential for the training of staff, for the stimulus it gives to workers to look beyond the immediate task in hands and for its benefits in creating clear and logical thinking. Universities are a natural focus for research. They can usually provide facilities which smaller bodies cannot, they attract skilled personnel and, because of their position, they obtain a large proportion of available donations and grants. In Chapter 8 the Commission recommends considerable improvements in the

training of medical staff, and accordingly regards some University research as essential. University research, however, is sometimes criticised on the basis that it is usually under the aegis of a professor whose primary interest is teaching and that, where it is concerned with applied research, it is frequently based on a specialised unit which does not contain a representative sample of patients. The Commission does not consider that these criticisms would apply to all Irish Universities, but they suffer from another disability as centres for research on mental illness. State help to the Universities is provided mainly by way of block grants which the Universities spend in the manner they think best. The demands for money for research on mental illness would have to compete with demands for money for other forms of research, for teaching, for equipment, and for all the other requirements of Universities. While the Commission thinks it essential that the psychiatric departments of the Universities should do some research it does not consider it likely that they will do enough to meet more than a portion of the need, or that five bodies (there are five medical schools) working independently will serve the national needs. **In order to overcome their financial difficulties to some extent at least, the Commission suggests that Universities should consider co-operating with other agencies in carrying out particular research projects—see paragraph 151.**

The Medical Research Council

The Medical Research Council was incorporated on 26th January, 1937. It is a company limited by guarantee and not having a share capital. Its function is to organise and carry out research work in medicine. It is financed in the main by an annual grant made by the Minister for Health. It also receives grants from time to time from commercial and other sources. The Council consists of 8 members nominated by the Universities and other medical licensing bodies. The Chairman is nominated by the Minister for Health. The Council devotes most of its energies to basic research. **In the Commission's view it would be a suitable body to carry out some psychiatric research, but it would not be the most suitable organisation to undertake responsibility for the greater part of the psychiatric research required in this country.**

The Medico-Social Research Board

This Board was established under the Medico-Social Research Board (Establishment) Order, 1965, with the following functions :—

(a) to organise and administer such surveys and statistical research in relation to the incidence of human diseases, injuries, deformities and defects and in relation to the

provision and operation of health services as the Minister for Health may direct or as may be approved by him;

(b) to advise the Minister on such matters as he may refer to them relating to the incidence of human diseases, injuries, deformities and defects and the compilation and use of health and vital statistics.

It would seem that much of the research into mental illness which will be carried out in this country, in the immediate future at least, will be of a type which this Board would be suitable to perform. It is not yet clear, however, how the Board will operate and it is impossible to make firm recommendations as to the role it should fulfil.

Development of Research

151. The Commission expects mat the departments of psychiatry in the medical schools will carry out psychiatric research. It recommends that the Medico-Social Research Board or some other suitable organisation, should be given the task of co-ordinating research projects in the country. The organisation chosen should itself, or in co-operation with other bodies, or with individuals, arrange for specific schemes of research. The Minister for Health, the Health Authorities, the National Advisory Council (see paragraph 187) and other interested bodies and individuals should suggest suitable subjects for research. The Commission recommends that the Minister for Health should provide funds for research.

The National Advisory Council could advise, at a later date, whether the Medico-Social Research Board or some other organisation should be given the task of co-ordinating research projects and arranging for specific schemes of research.

CHAPTER 8

EDUCATION AND TRAINING

General

152. Ultimately the quality of a mental health service depends on the availability of adequate and well-trained staff to operate it effectively. In the development of psychiatric services, therefore, it is essential that priority should be given to the education and training of professional staff and that a considerable part of available resources should be devoted to this work. Apart from professional staff, many of the general public, such as teachers and clergy, could make a worthwhile contribution to the service if they were given a greater appreciation of the needs of psychiatric patients. The Commission discusses in this Chapter the more important areas in which it feels that programmes of education and training should be extended.

(a) MEDICAL EDUCATION

Organisation of Medical Education in Ireland

153. There are five medical schools in Ireland which provide training leading to qualification as a medical practitioner. These are the medical faculties of University College, Dublin, University College, Cork and University College, Galway (three constituent colleges of the National University of Ireland), Dublin University (Trinity College), Dublin, and the Royal College of Surgeons in Ireland, Dublin. In addition, the Apothecaries Hall of Ireland grants a licence (L.A.H.), but does not instruct medical students—the licence is granted on the basis of attendance at courses recognised by it in relevant subjects. In the speciality of psychiatry at post-graduate level, University College, Dublin, provides a special course of instruction leading to the Diploma in Psychological Medicine. Dublin University and the Royal College of Surgeons in Ireland also offer the Diploma in Psychological Medicine, but do not provide a special course of instruction.

The following table sets out the numbers graduating from the Irish medical schools during the academic years 1961 to 1965, distinguishing between Irish students (Ireland including Northern Ireland) and overseas students.

	Primary Degrees, Medicine											
	19 Bl		1062		1063		1064		1065		Total	
	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas
University College, Dublin.	61	18	47	15	52	17	63	20	66	30	260	100
University College, Cork.	16	2	10	2	12	4	24	8	25	2	87	18
University College, Galway.	8	7	14	7	14	7	10	6	18	7	64	34
Trinity College.	21	28	24	22	24	81	13	25	20	25	102	131
Royal College of Surgeons.	28	37	21	63	13	57	12	64	13	62	87	283
Grand Total	124	02	**110**	**100**	115	116	112	**123**	132	**126**	**600**	**566**

During the same period Diplomas in Psychological Medicine were granted as follows:

	1061		1962		1063		1064		1065		Total	
	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas	Ire-land	Over-seas
University College, Dublin.	1	3	3	0	7	1	3	1	6	1	10	6
Trinity College.	0	1	4	1	1	2	2	8	1	3	8	10
Royal College of Surgeons.	6	1	4	1	2	1	3	2	3	2	18	7
Grand Total	7	6	11	2	10	4	8	6	0	0	45	23

Of 95 medical officers employed in district mental hospitals in 1963, 70 had been granted their primary qualification by one of the constituent colleges of the National University of Ireland, 20 by the Royal College of Surgeons in Ireland, 1 by Dublin University, 3 by the Apothecaries Hall and 1 by a medical school outside Ireland.

Undergraduate Education

154. The quality of psychiatric training provided for undergraduates is important for a number of reasons. It is particularly

important because of the contribution which general practitioners are called upon to make to the care and treatment of the mentally ill—see paragraph 82. A specialist psychiatric service centred on district clinic services and in-patient treatment in general hospitals and mental hospitals can be effective only if it can rely on the co-operation of general practitioners who understand the broad principles of modern psychiatry. The Commission is of the opinion that, at present, medical practitioners in general are not sufficiently aware of those principles to make an effective contribution to the psychiatric services. This, to a considerable extent, must be attributed to serious deficiencies in undergraduate education. In the Commission's view, the time allotted to psychiatry in the curricula of the various medical schools is inadequate in relation to the importance of the subject in medical practice. The emphasis is on physical medicine, to the virtual exclusion of psychological medicine, in which subject the instruction given does not produce an adequate appreciation of the importance of social and psychological phenomena. The total staff available for teaching is grossly inadequate. There is **a** Chair of Psychiatry in one school only and even this is a part-time post.

It is now well accepted that undergraduate instruction in psychiatry cannot be left to develop as a side issue of the daily clinical activities of a number of consultants. Wholetime Chairs of Psychiatry are regarded as essential to organise a properly balanced programme. **The Commission recommends that a wholetime Chair should be established at each of the Medical Schools in Ireland so that instruction in the subject can be placed on a** satisfactory **basis.** The term wholetime is a relative one—it is intended to describe a post the holder of which is primarily concerned with teaching, does not take part in private practice and has not a number of time-consuming responsibilities in addition to responsibility for teaching; it does not, however, exclude treatment of patients. **Indeed, it is essential that a professor should have a psychiatric unit under his control to ensure that he keeps abreast of clinical developments.** This unit should be large enough to provide an adequate number of patients and a sufficiently wide range of illnesses for teaching purposes. A psychiatric unit of 50-100 beds caring for short-term patients would be suitable, provided that the professor also had ready access to long-stay beds and community services. While the professor should not engage in private practice, he could be allowed to undertake limited consultant practice not involving prolonged treatment.

The Commission considered that it should not make detailed recommendations in regard to the curricula in the various schools. **It recommends however, that certain principles should be applied in every programme of undergraduate training.** Many medical schools have revised their curricula in recent years. Most of them have incorporated these principles in the revised curricula. In **a** high proportion of medical schools in the United States of America the principles have actually been translated into practice for 15 years or more. These principles are :—

(1) Psychiatry should be taught as a major clinical subject. Instruction in psychiatry and in the disciplines which are related to it should be given throughout the whole course of medical education and should be closely integrated with training in other biological and clinical disciplines.

(2) In courses of instruction in animal and human biology, which are usually given during the first 2.5 years, due emphasis should be given to human behaviour in its psychological and social as well as physiological aspects. If instruction in the preclinical course is focused narrowly on the study of the formalin-fixed cadaver and on time-honoured topics in human and animal physiology, there is a danger that the student will acquire a narrow mechanistic approach towards human disease. He may then fail to approach the patient as a person in the round during his clinical training and in his subsequent work as a doctor. This part of the course should be leavened, therefore, with instruction in social and experimental psychology, sociology and anthropology as well as the elements of statistical method.

(3) **For effective instruction in psychiatry students should be organised into small discussion groups.** An enlightened appreciation of psychiatric concepts cannot be achieved by desk lectures and demonstrations of the traditional type.

(4) **Provision should be made for a course dealing with the evolution of human personality and its characteristics during different stages of the life-span. This, as far as possible, should be integrated with other teaching in medicine and should begin with a course on psychological development in childhood, closely integrated with relevant teaching in paediatrics.**

(5) Each student should have a full-time clerkship in clinical psychiatry. Students should be resident during part of this course which should be spent partly in a general hospital unit and partly in a mental hospital.

Post-graduate Education

155. The Commission considers that existing facilities for post-graduate education in psychiatry are most inadequate. Three of the medical schools offer a Diploma in Psychological Medicine, but two of these do not offer any course of instruction. In relation to training and experience, all three simply prescribe service of any kind in **a** mental hospital. Post-graduate training in psychiatry demands carefully supervised experience and instruction in the diagnosis and treatment of mental disorder and the post-graduate student has to encompass a wide range of disciplines. Although the main emphasis in the course of training must be on diagnosis and psychological and physical treatment, experience and instruction in

psychopathology, child psychiatry, social and community psychiatry, forensic psychiatry, neurology, psychosomatic medicine and in pharmacology and biochemistry are essential.

The post-graduate student needs a variety of clinical experience and should be exposed to the influence of a number of teachers. Senior members of the teaching staff must plan the experience of the student if he is to be presented with a carefully woven fabric of knowledge rather than a patchwork product resulting from the unco-ordinated efforts of a number of individuals.

It will be seen from paragraph 153 that the Irish medical schools have only a small number of post-graduate students to deal with. Even allowing for a general increase in demand in future years, the Commission considers that it would be difficult, if not impossible, for all the medical schools to mount a programme of post-graduate education on the lines summarised above. **It appears to the Commission that some form of co-operation between the schools will be necessary to achieve the desired standards. The exact form that this co-ordination should take can best be decided after detailed discussion between the educational bodies concerned.**

(b) PSYCHOLOGISTS

General

156. In this country a few psychologists are employed in Child Psychiatric Services, but in the general field of mental illness the employment of psychologists is practically unknown. In other countries the psychologist is frequently a member of the mental health team.

It is important to keep in mind the differences between the psychologist, the psychotherapist and the psychoanalyst. The Commission uses these terms in the following ways. Psychology may be defined as the systematic study of mental life, abilities, emotions, attitudes and behaviour. A psychologist is a person who has had adequate training in this subject. A psychotherapist is one who is engaged in the healing of sick minds by psychological means, without being committed to any one theory or method. A psychoanalyst is one who subscribes to a particular theory of the aetiology of mental illness, has himself been analysed, belongs to one or other of the Institutes of Analysis, and limits his thereapeutic procedure almost exclusively to a particular method of psychotherapy. Usually (except in the U.S.A.) both psychotherapists and psychoanalysts are medically qualified and trained in psychiatry, but neither has the professional training of a psychologist.

Psychologists work in a number of other fields, such as industry and education. Those who have specialised in clinical work are known as clinical psychologists. They are not usually medically qualified, and they work in close association with psychiatrists. Their functions are:—

(i) To assist in **diagnosis.** For this purpose the clinical psychologist must be familiar with a wide variety of reliable standardised tests. These enable him to make quantitative assessments of intelligence, educational attainment, special aptitudes and various aspects of personality. While mental handicap is peculiarly his province, his findings in respect of mental illness and personality disorder are also valuable. He is able to make a special contribution in the diagnosis of brain damage or disease.

(ii) To assist in **therapy. In** this field he works under the guidance of the psychiatrist, who must take full control. He may take part in play therapy with children, in occupational therapy and in various forms of group therapy. He can help in rehabilitation by assessing residual skills, advising on teaching methods and giving vocational guidance. He may have a special interest in the application of learning theory to psychiatric illness. He may also assist in individual psychotherapy, if he has a special aptitude for this work.

(hi) **Research.** The psychologist should be actively engaged in research, for which he is particularly well qualified through his knowledge of statistics, and of quantitative methods. As a member of the psychiatric team, he should take part in the design of scientific research programmes, and he may be expected to be closely involved in the special problems of his own hospital, area and country.

Training Facilities in Ireland

157. Psychology is studied as a separate discipline in three university colleges in Ireland, viz. University College, Dublin, University College, Cork, and Trinity College, Dublin. University College, Dublin provides a full-time two year course leading to a Diploma in Psychology. Persons holding honours diplomas in psychology (or persons who have achieved a high standard in an equivalent qualification) can present themselves for the degree of Master of Psychological Science, which is awarded on a research thesis at least three terms after the Diploma. University College, Cork offers an honours degree course extending over four years, three undergraduate years and one final, full-time fourth year. Trinity College, Dublin does not at present provide **a** course leading to qualification for professional work in psychology. It is understood, however, that consideration is being given to the provision in this College, in the near future, of training facilities leading to qualification as a clinical psychologist.

158. There are many types of course leading to a qualification in psychology. The conteni of such courses and the amount of super-

vised experience provided varies to a considerable extent. The Commission recommends that a University course embracing laboratory work and supervised clinical experience as well as a full grounding in academic psychology, or the equivalent of such a course, should be regarded as the necessary qualification for psychologists who practise in the psychiatric field.

At present about 18 psychologists qualify each year for professional work in psychology. Many of these practise in other fields such as industrial psychology. A substantial increase in training facilities would appear to be necessary to ensure that the output of qualified psychologists will be sufficient to meet the demands of expanding services for the mentally handicapped and the mentally ill.

(c) PSYCHIATRIC NURSES

General

159. Although the chief function of the psychiatric nurse is to render personal service to the patients in a hospital, in recent years changing techniques of treatment, the greater emphasis on community care and the tendency towards the earlier discharge of patients have had a profound effect on the nurse's role. Much greater significance is now attached to the social aspect of treatment and this involves the acquisition of many new skills on the part of the nursing profession. Apart from the day-to-day care of the patient, the nurse must now be equipped to educate the patient's family to understand the needs of his illness, to participate in occupational therapy and to understand the importance of social factors in mental disorders. Throughout the world these changing needs have led to modifications of nurse training curricula.

The greater responsibility now devolving on nurses has led the Commission to the view mat psychiatric patients should not be nursed by persons other than fully trained psychiatric nurses. The Commission appreciates, of course, that in the psychiatric units recommended in paragraph 37 there will be a number of students in various stages of training and general trained nurses seeking experience in psychiatric nursing, but it considers that all such persons should operate under the direct supervision of trained psychiatric nurses.

Organisation of Psycliiatric Nurse Training in Ireland

160. An Bord Altranais, a statutory board established under the Nurses Acts, 1950 and 1961, controls the registration, training and certification of nurses witiiin the State. An Bord conducts nursing examinations and is empowered to provide courses, grant scholarships and provide hostel accommodation. At present there are 24 hospitals approved as training schools for psychiatric nurses; twenty of these are local authority hospitals and four are private hospitals. The period of training is normally 3 years, but a shortened period of training is available for general trained nurses and nurses of the

mentally handicapped. Before registration, a student is required to complete the prescribed training and, in the case of those pursuing the full basic course, to pass a Preliminary Examination and a Final Examination. The Preliminary Examination consists of a written paper, an oral test conducted by two medical examiners and a practical test conducted by two nurse examiners. The Final Examination at present consists of:—

(i) a written paper on the Practice of Nursing,

(ii) a written paper on Psychology and Psychiatry,

(iii) a written paper on The Body in Health and Disease,

(iv) an oral examination conducted by two medical examiners,

(v) a practical examination conducted by two nurse examiners.

Students who are not successful at the whole examination, when being re-examined, may be given credit for the part in which they have satisfied the examiners.

Examinations in psychiatric nursing are held in the months of May and November. The entries and results for these examinations over the past three years were as follows :—

	Preliminary		Firlal	
Year	Entries	Passes	Entries	Passes
1963 ..	463	386	265	239
1964 ..	376	314	313	261
1965 ..	326	266	385	333
TOTAL	1,165	966	963	833

The pass mark in each section of the examination is 50 per cent. From the above table it may be seen that at the Preliminary Examination a fairly high percentage of the students fail to satisfy the examiners. It is understood that, in the main, the students who fail are rejected in the written part of the examination.

Integration of Training Courses for Nurses

161. There is a noticeable international trend towards a pattern of common basic training for nurses followed by further courses of training for specialisation in particular fields such as psychiatry, midwifery, mental handicap, and general nursing. The Commission gave particular attention to the trend in view of its relevance to the organisation of psychiatric nurse training in Ireland. The Commission is satisfied as a result of its investigations that, while this common basic training has many desirable features and may eventually be adopted in Ireland, there is no immediate prospect of its being introduced here. Consequently, the Commission has framed its recommendations on the basis that the existing independent train-

ing systems will operate for some time to come. However, it recommends that An Bord Altranais should encourage individual training schools to experiment with schemes of common basic training for all nursing grades. The Commission also considers it desirable that general and psychiatric nurse training should be more closely integrated and, towards this end, it recommends the following interim measures—

(a) that joint training schemes be established in neighbouring approved psychiatric and general hospitals on an experimental basis;

(b) that the training period for qualification be reduced to 18 months in the case of general trained nurses undertaking psychiatric training and psychiatric nurses undertaking general training;

(c) that all nurses undergoing general training spend a period of at least three months full-time training and instruction in accordance with an approved syllabus in a psychiatric hospital;

(d) that all nurses undergoing psychiatric training spend a period of at least three months full-time training and instruction in accordance with an approved syllabus in a general hospital, preferably a hospital incorporating a training school.

In order to implement (d) it will be necessary to provide for a great increase in the facilities for general training of male nurses within the State. It is understood that at present these facilities are very limited and most male nurses are obliged to go abroad to obtain general training.

Present Training Scheme

162. Subject to the recommendations in this report, the Commission approves generally of the scheme of training for psychiatric nurses prescribed by An Bord Altranais. However, from observations and discussions during its visits to mental hospitals in Ireland, the Commission considers that the training programmes and facilities could be improved in most centres. Training schools should be regularly reviewed or inspected and pressure maintained to ensure mat they reach the required standard. When a hospital has not attained the requisite standard it should be given a period of grace in which to do so. Should it fail to come up to this standard it should then be struck off the list of training schools. The Commission feels that a forceful approach is required to stimulate this process of improvement. It is aware that An Bord Altranais has an inspection system, iJ[1] f*[els] *.** A" Bo*[1] *should* expand and intensify this system.

The Commission noted in particular that many hospitals had failed as yet to implement satisfactorily the introductory course for newly recruited student nurses. The Commission recommends that, where hospitals fail to provide suitably organised courses within a reason-

able period, consideration should be given to the provision of such courses for groups of hospitals at suitable regional centres.

In Chapter 4, the Commission has recommended the organisation of future hospital services for the mentally ill on the basis of (a) short-term units in or associated with general hospitals and (b) long-stay hospitals. The Commission wishes to stress that, under this organisation, it will be necessary to devise a system of secondment or interchange of student nurses between the two types of centre to ensure that all obtain **a** sufficiently wide clinical experience.

Recruitment of Student Nurses

163. **The Commission considers that the minimum age of entry for student psychiatric nurses should be reduced from the present level of 18 years to 17 years, as this is the age at which many students finish their secondary education.** The Commission considers that many students of this age are sufficiently mature to undertake the training course and indeed are at the most receptive age for training.

During the course of the visits to mental hospitals members of the Commission noted that there were considerable local variations in selection criteria for student nurses. **The Commission considers that a high standard of general education is required if students are to complete successfully the psychiatric nursing course. While it hopes mat, ultimately, the Secondary Schools Leaving Certificate will be specified as the minimum educational qualification it recommends that Intermediate Certificate (or its equivalent) should for the present be stipulated as the minimum qualification. The Commission strongly recommends that candidates should not be accepted for training unless they possess this minimum educational requirement** The Commission feels that talks to children of school-leaving age by experienced psychiatric nurses can do much to stimulate the recruitment of suitable persons to psychiatric nursing. Such efforts would be considerably assisted by the lowering of the minimum age of entry to 17 years. The Commission suggests that girls and boys of school leaving age should be brought to see psychiatric nurses at work in a psychiatric in-patient unit, as this may impress on them the importance of psychiatric nursing as a career.

Domiciliary Nursing

164. The Commission considers that the psychiatric nurse of to-day should undertake some domiciliary work appropriate to his or her function as a psychiatric nurse. The Commission has given much thought to the respective roles of the many kinds of professional people engaged in helping psychiatric patients, and particularly to the roles of nurses, psychiatric social workers and occupational therapists. It has concluded that it is impracticable to draw hard and fast lines of distinction between the roles of these professional workers in the field of psychiatry. The Commission prefers to emphasise the need for team work and considers that, in a suitably-functioning

team, each member should be conscious of the patient's needs, and of the kind of help that can best be supplied by his fellow workers—see paragraphs 76 and **77.**

Because of the increasing emphasis on domiciliary care, the Commission recommends that instruction about the social services and out-patient and domiciliary work, should be included in the curriculum of the student nurse.

Refresher Courses

165. The Commission considers that there is an obvious need for regular refresher courses both for senior and junior qualified psychiatric nurses. These could include courses, preferably residential, of about a fortnight's duration, for nurses selected from a number of hospitals. Refresher courses could also be organised by individual hospitals for their own staffs; such refresher courses, incorporating lectures and discussions, should be held at least once every year. Courses for senior nursing staff are particularly desirable. For all courses lecturers from outside the hospital could, with advantage, be introduced. In addition to courses, arrangements should be made, wherever possible, for exchange of staff between hospitals for short periods.

Library Facilities

166. Nurses should have access to a good library, both before and after their registration. It is particularly important that tutors and other senior members of the nursing staff should have access to books of reference and periodicals and that they should be encouraged to keep up-to-date in their reading. Adequate library facilities have not yet been provided in many hospitals. **The Commission recommends that suitable library facilities should be provided in every hospital.**

Training in Group Leadership and Activation

167. Training in general nursing can be an important asset to nurses seeking promotion in the mental health services. However, circumstances, economic and otherwise, can operate to prevent suitable qualified psychiatric nurses from undertaking general training and thus deter them from competing for higher posts. **The Commission considers that training and experience in group leadership and activation is of major importance in present day psychiatric nursing and that special courses to provide this training could be organised at local centres. It recommends that such courses should be organised; it is of opinion that many nurses who are unable to undertake general nursing would be willing to participate in these courses. The Commission suggests that adequate training and experience in group leadership and activation should be regarded as equivalent to training in general nursing, for marking purposes, when candidates are being selected for higher posts in the service.**

(d) SOCIAL WORKERS

General

168. The need for social workers and the respective roles of such workers and nurses in community care are discussed in paragraphs 76 and 77. The basic qualification for a social worker is a diploma or a degree in the social sciences. A psychiatric social worker is a social worker who undertakes a further period of supervised practical training and a course of study in psychology and psychiatry. The exact training programmes leading to qualification as a psychiatric social worker vary considerably from country to country but generally include—

(a) a period of training—usually one year—in a psychiatric hospital;

(b) a further year in a university during which the academic side of mental health and mental illness is studied, and

(c) a period of supervised training on case work.

Variations of this include (1) a training scheme whereby, after training in social studies, the student works in a mental hospital as a trainee under the supervision of an experienced psychiatric social worker; after two years as a trainee, the student may take a shortened form of the psychiatric social workers course and (2) a scheme under which the student takes a course of one year in general social work (a post social studies course) with four extra months of supervised practical work in psychiatry.

Social Workers—Training Facilities in Ireland

169. Two university centres in Ireland provide basic training courses in social work. University College, Dublin, provides a three-year degree course in Social Science, which, however, must be followed by a one-year diploma course to qualify a student for social work. A two-year diploma course for non-graduates is also available. Dublin University provides a four-year degree course or a two-year diploma course. **The Commission is satisfied that these courses will produce social workers in sufficient numbers to meet the needs of the psychiatric services recommended in this report.**

Psychiatric Social Workers—Training Facilities in Ireland

170. Specialised training facilities for psychiatric social workers have not yet been fully organised in Ireland. However, the basic training (Bachelor of Social Science or Diploma in Social Science and supervised casework) is already available in University College, Dublin and in Trinity College, Dublin. The degree of Master of Social Science has recently become available in University College, Dublin, and it is understood that plans for the more specialised training required for psychiatric social work are well advanced—

present indications are that it will ibegin in October, 1967. It is envisaged that this will also be a Master's degree, and the course will provide post-graduate students with professional training in psychiatric social work and family casework. It will probably take about eighteen months to complete this training (after the Bachelor's degree).

At present there are about ten fully qualified psychiatric social workers in Ireland. **Expanding services for the mentally handicapped and the mentally ill will increase considerably the demand for the services of psychiatric social workers. The Commission recommends that facilities for their training in this country should be extended.**

(e) OCCUPATIONAL THERAPISTS

General

171. Occupational therapy, as the title implies, is the art of providing sick and disabled persons with occupations that help to cure them. The occupational therapist is a person professionally trained to do this work.

As discussed in paragraphs 52-57, there have been considerable advances in recent years in the range and purpose of organised activities in psychiatric hospitals, particularly in those catering for long-stay patients. These developments have induced some authorities to suggest that there is no place for the occupational therapist in the modern mental hospital. The advent of industrial therapy organised on factory lines, the more realistic approach to the therapeutic value of work in the utility departments of hospitals and the increasing use of farms for market gardening and horticultural activities are all cited as developments to which the skills of the occupational therapist can make little contribution.

Despite these suggestions, the Commission is satisfied that the occupational therapist has an important role in the psychiatric team, particularly with long-stay patients. The therapist's skills are particularly useful in preparing the long-stay patient for work in industrial therapy units and utility departments. Many long-stay patients are bedfast and the skills of the occupational therapist are particularly appropriate to them. The organisation of recreational activities, which play an important part in long-term care, is also particularly suited to the occupational therapist. Occupational therapy forms a considerable part of the work of the psychiatric nurse and the occupational therapist can give valuable instruction in the Nurse Training School.

Training Facilities in Ireland

172. Very few qualified occupational therapists have yet been **employed** in mental hospitals in Ireland and this must be attributed largely to the fact that training facilities were not available until recently. Under the auspices of the National Organisation for Rehabilitation, **a** three year course leading to **a** Diploma in Occupa-

tional Therapy is now provided at St. Joseph's College of Occupational Therapy, Diin Laoghaire. A shorter course is available for some candidates holding special qualifications, including psychiatric nurses. The course commenced in 1963 and the first group of students taking the shorter course graduated early in 1966. Six of these were psychiatric nurses and they have been absorbed into the mental health services.

The Commission is satisfied that the present course of training is in keeping with internationally approved standards, and will serve to produce occupational therapists capable of doing the work required of them in psychiatric hospitals. The Commission recommends, however, that particular attention should be paid to changing conditions in the psychiatric field and that, to meet them, adjustments in the course of training should be made from time to time.

(f) MENTAL HOSPITAL CHAPLAINS

General

173. **The Commission considers that the mental hospital chaplain has an important part to play in the treatment of the mentally ill.** In contradistinction to the expressed attitudes of many leading psychiatrists in the past, there is now general agreement among psychiatrists throughout the world that good psychiatry and religious counselling do not conflict and that the two are closely related and indispensable in the proper care of the psychiatric patient.

The patient has a right to ready access to the services of his Church. In the case of the Catholic patient—and the great majority of patients in this country are Catholics—this means the provision of Mass and the Sacraments and the preaching of the Word of God. It also means the personal attention of a priest to the patient's spiritual needs, and personal treatment of his spiritual problems.

The selection and training of chaplains and the laying down of the duties they are to perform are, of course, matters for the appropriate ecclesiastical authorities. In order, however, that the work of the mental hospital chaplain may be productive of the best results, it is desirable that the patient should be able to establish a continuing relationship with the same person. While the hospital chaplain is not a psychotherapist, it is necessary that he should have some understanding of psychiatry and psychology, in order to ensure that his care of the patient will be as effective as possible. A continuing relationship with the same person, who at one and the same time can minister to his spiritual needs and understand the nature of his illness is most efficacious in the final rehabilitation of the curable patient, as well as in the care of the long-stay and deteriorated patient.

^ **The Commission accordingly recommends that ecclesiastical authorities should give particular consideration to the training of chaplains and to the role they are to fill in the mental hospitals.** The Commission's views on these matters are set out in the following paragraphs.

Training Facilities

174. Courses in psychology and professional training in counselling are of the greatest value in helping the mental hospital chaplain to carry out his role in serving the mentally ill. It is suggested that more use should be made of short three-day or four-day conferences on the lines of those undertaken from time to time in the St. John of God Psychiatric Hospital, Dublin, in order to give chaplains and other clergy a better insight into the specific problems and difficulties of the mentally ill. It is also desirable that, where possible, mental hospital chaplains should attend extended courses in training. A course of the type the Commission has in mind is provided at St. Elizabeth's Hospital in Washington, D.C., in conjunction with the Catholic University of America.

Role of the Mental Hospital Chaplain

175. A hospital, even though it has become more and more part of the social life of the community around it, is still a community of a special kind and with a life and structure of its own. For this reason, its religious needs should be met from within, by someone who belongs to it and shares its life. Much of the efficacy of the chaplain's work depends on his knowing and understanding his people, and on the establishment of bonds of affection and esteem between them.

A chaplain must decide who should and who should not attend Mass or Church Service, who should receive the Sacraments, and who needs spiritual instruction. He must attend to the spiritual needs of the dying. These tasks require the attention of a chaplain specially trained for such work. The chaplain can be of great help to staff and relatives as well as to the patient. Very often the psychiatrist realises better than anybody else the confusions that arise in the patient's mind in the areas where psychiatry and religion are most closely related, and seeks the help of a chaplain as a necessary means to clarify the issues for the patient. Co-operation between psychiatrist and priest or minister, without confusion of either's role, can only be for the good of all.

Because of the arduous nature of the work, it is suggested that chaplains be appointed for periods long enough to enable them to establish the close relationships indicated above, but not indefinitely —a five or six year period might be considered.

(g) PROGRAMME OF PUBLIC EDUCATION

General

176. Full support from the community is essential to the organisation of effective psychiatric services, whether preventive, therapeutic or rehabilitative. Enlightened social attitudes will encourage the mentally ill to seek treatment, promote co-operation in therapeutic programmes, create a climate favourable to swift rehabilitation and

diminish the unconscious cruelty or unkindness which is a feature of all societies which are not aware of the needs of the mentally ill. The repair and renewal of social contact is a necessary part of therapy and this can be made unnecessarily difficult in a community mistrustful of psychiatrists and of the mentally ill. Moreover, only an informed and willing society will be prepared to accept the additional financial burden of improving existing psychiatric services and introducing new ones. **More than one-third of all the beds in Irish hospitals are occupied by mentally ill persons and probably one in three of the patients attending general practitioners present some psychiatric features. The duty of the community towards all those who suffer as a result of mental illness must be brought home convincingly to the ordinary people of the country. Public enlightenment has increased greatly during recent years, but much remains to be done. The Commission recommends that there should be a positive programme of public education and that it should be the responsibility of the Minister for Health to encourage its development in every way possible.** The Commission visualises that the programme would operate mainly through professional workers in the field of mental health, through key personnel in the community and through the mass media of communication. The role of specific groups or agencies is discussed in the following paragraphs.

Psychiatric Services

177. In the past, psychiatric hospitals were regarded as centres of custodial care. Usually they were surrounded by high walls and were isolated from the public. Their change into places of treatment, the improvement of buildings and facilities, the removal of high walls, the holding of open days when the public are invited to see all parts of the hospital, the introduction of the open-door system and the abolition of unnecessary restrictions on patients will do much to improve the attitude of the public to psychiatry. **It is however, the improvement of services and their extension into the community which will make the greatest impact.** There is no better advertisement than the successful treatment of patients. In addition to improving and extending services, psychiatrists, psychologists, nurses and other professional workers can help considerably by attending at discussions and seminars, by the publication of articles, by giving talks to other professional workers, to employers and to persons interested in the mentally ill and, by trying in other ways to create a proper appreciation of the problem of mental illness and to encourage the adoption of an enlightened attitude towards it.

Professional Workers in other Health Fields

178. Professional workers in other health fields can supplement the efforts of professional workers in the psychiatric field. The contribution which the general practitioner can make to the treatment services has been stressed in paragraph 82. He is usually in touch with the patient before he receives psychiatric treatment and after

the treatment is finished. He can do much to influence individual and family attitudes and his position in the community enables him to assist in spreading accurate knowledge about psychiatry and to help to break down the ignorance and attitude of distrust which unfortunately persist still in some places. Public health personnel, through their many contacts with the public, can do much to influence public attitudes. General hospital staff can help to spread enlightenment, particularly in regard to the close link between physical and mental illness. With proper education, and with good-will, all workers in the health field can help to create a better understanding of the problem of mental illness.

Teachers

179. The role of teachers in regard to mental disorders in children has been stressed in Chapter 6. The Commission has welcomed the fact that some instruction on child development is now given in teachers' training and refresher courses. The influence of the teacher extends beyond the school to the community at large and, if he is given an appreciation of psychiatric problems, he can help to extend that appreciation to the general public.

Clergy

180. The very nature of their pastoral role in society places the clery in an exceptional position to influence community attitudes. In addition, they are frequently responsible for the management of schools and institutions for the young and so are in a special position to influence the attitudes of young people. Apart from their capacity to influence the community in general, they are also well placed to influence the individual. Very often the priest is the first person to whom relatives turn for help when one of the family becomes mentally ill. Indeed, many mentally ill persons in the community consult a priest even before they seek medical advice and frequently maintain that contact during the course of treatment. **The clergy's potential contribution to any organised scheme of psychiatric services is thus enormous. Not alone can they help to further public enlightenment, but they can also advise individual patients to seek and continue treatment. It follows that clergy should be well-instructed in the basic principles of mental hygiene.** The Commission is aware that a number of seminars have been held already. It welcomes this development and hopes that further seminars and courses of study will be provided.

Garda Siochana

181. In the ordinary course of their duties the gardai often encounter mentally and emotionally disturbed persons whose behaviour leads to domestic crises or actual conflict with the law. They often have to deal with children and adolescents whose anti-social behaviour is merely **a** reaction to an adverse home environ-

ment. Again, as guardians of the peace they are in a position to influence attitudes of society towards mental illness. **The Commission considers it desirable that all gardai should receive instruction in the behavioural consequences of mental illness or emotional disturbances, especially in children and adolescents, and it recommends that appropriate provision be made in the training courses undertaken by gardai.**

Legal Profession

182. Practising lawyers and judges should know enough about patterns of abnormal behaviour to appreciate their importance in offences against the law. Many delinquents and recidivists are suffering from mental disorders : an appreciation of basic motivational factors would considerably assist a judge in court and would assist him to recognise those cases in which psychiatric opinion is necessary. The Commission believes also that it would be a good thing if members of the legal profession were to take some part in psychiatric community care. Family solicitors should be encouraged to advise clients, where appropriate, of the need for psychiatric attention for members of their families. **The professional bodies should be encouraged to raise the level of informed appreciation of the problems of mental illness.**

Trade Union Officials

183. Trade union officials should help to educate workers to appreciate the needs of psychiatric patients returning to their employment. Helpful support from fellow workers in the rehabilitation stage can be of the greatest value. The degree of competition for posts in Ireland may often intensify the usual difficulties in forming relationships experienced by a patient at this time. Many psychiatric patients have had to cease work temporarily in order to seek treatment, and they are entitled to the understanding and wholehearted support of their colleagues on their return to the community. **The Commission recommends that trade unions should be encouraged to educate the general body of workers to adopt an enlightened attitude towards mental illness.**

Press, Radio and Television

184. The attitude of the public to psychiatry has been influenced by many agencies, prominent among which are the press, radio and television. Moved by the commercial need to entertain rather than inform and educate these media of communication have tended to concentrate upon the more dramatic aspects of psychiatry and this has tended to produce a somewhat distorted idea of psychiatry among the general population. The influence of these media is enormous and their co-operation is essential if the programme of public education advocated in this chapter is to achieve its aim. **The Commission strongly urges that the appropriate authorities in**

these media should influence their executives to consult expert opinion on all programmes which are likely to affect public attitudes towards mental illness. This is particularly apposite in the case of television, as many imported television programmes tend to be highly sensational in their approach. The Commission suggests that the television authorities should appoint a panel of experts to advise on the presentation of programmes dealing with mental illness. Such an advisory panel might well be used by the Television and Radio authorities to design educational programmes in this field. The press could also help to educate the public by publishing informed articles on the many problems of mental illness.

Marriage Guidance Courses

185. The Commission considers that marriage guidance courses, both pre-marriage and post-marriage, can make a considerable contribution to the greater understanding of parental responsibilities and of the importance of healthy family relationships. It is aware that many courses have already been held **and it considers it desirable that they should be extended so that they may be available to all who can benefit from them.**

CHAPTER 9

ORGANISATION OF SERVICES

General

186. The White Paper on "The Health Services and their Further Development" issued by the Government in January, 1966, indicates that considerable changes are contemplated in the financial and administrative structure of the health services generally. The Commission is of opinion that the improved and extended services outlined in this report can be incorporated without difficulty into the general framework proposed in the White Paper. It considered, as detailed in the following paragraphs, the desirability of special organisations to deal with the problems of mental illness and the changes necessary in the present administrative and other staff structures.

National Advisory Council

187. The present is a period of change in the field of psychiatry. In a comparatively short time there has been, in many ways, a revolution in the approach to mental illness and the treatment of the mentally ill. However, many concepts and procedures are still in a state of evolution and new ideas are being tested continually. The Commission has recommended a pattern of services, based on current knowledge, but this pattern must be kept under review. In addition, the recommendations are confined, in many instances, to the main concepts and principles involved: detailed information on implementation and on some of the technical aspects will be required from time to time. The Commission's proposals involve fundamental changes in existing services and the establishment of new services: there will be a great need to ensure that all these services are co-ordinated with each other and with other health services. The Commission considers it very desirable that there should be an expert body to advise the Minister on these matters. **It recommends that a National Advisory Council should be established which, on its own initiative or at the request of the Minister, would provide advice on any matter relating to mental health services.** There are many organisations concerned with mental health. If all, or even **a** considerable proportion, were given representation on the Council an unwieldy body would be produced and delays would be inevitable. **The Commission recommends that the Council should be a small expert body containing not more than nine members. It should have power to invite the attendance of specialists and representatives of interested bodies to assist in its deliberations.** In this way the views of all interested bodies could be obtained.

National Voluntary Organisation

188. In many countries there is some form of voluntary national association for mental health. In this country, in the field of mental handicap there is The National Association for the Mentally Handicapped of Ireland. There is not, as yet, a similar body in the field of mental illness, but it is understood that the formation of a National Mental Welfare Association is proposed. The Commission welcomes this development. The services recommended in this report will require a considerable amount of money and effort. A national association can do much to influence public opinion and to ensure that the services for the mentally ill obtain a fair share of the national resources. It can also provide a common forum for the different professional and other workers in the field of health and persons interested in the problems of the mentally ill. It can organise seminars and meetings, issue booklets and pamphlets for the information of the public, arrange for the distribution of suitable films and, in general, help to advance the cause of the mentally ill. **The Commission recommends that full support should be given to the formation of a national voluntary body.**

Joint Use of Facilities

189. The Commission stresses the desirability of integrating psychiatry and general medicine. In Chapter 4 it recommends two main types of accommodation—short-stay units and long-stay units. In most cases the short-stay units will be established at, or in association with, general hospitals and should result in the desired integration. The long-stay units will be at existing mental hospitals, in such buildings as can be suitably adapted and renovated, or in specially designed new residential accommodation. In these long-stay units the emphasis will be on rehabilitation and retraining; there will be well organised occupational therapy departments, as well as facilities for hobbies, recreation and social activities. At many, there will be industrial therapy units. The whole aim will be to offer the patient an opportunity for a full and active life, in preparation for return to the community. The units will be, in effect, rehabilitation hospitals and could well be described by that name. Many of the facilities in them could be used, quite readily, in the rehabilitation and retraining programmes of persons with various physical handicaps and disabilities. At medical level they will be staffed mainly by psychiatrists, but other specialists will be available also and the Commission has recommended that general practitioners from the area should be employed as part-time clinical assistants. In this way **the** long-stay units would help to promote the integration of psychiatry and general medicine. **The Commission recommends that, as rehabilitation services are developed the units should extend gradually the scope of their activities to include the accommodation, rehabilitation and retraining of persons suffering from illnesses which are predominantly physical, e.g. persons suffering from certain forms of orthopaedic, pulmonary and cardiac disabilities.**

Medical Staff Structure

190. At present there are three main grades of medical staff in district mental hospitals—Resident Medical Superintendents, Senior Assistant Medical Officers and Assistant Medical Officers. The Commission considers that the improved and extended services recommended in this report will necessitate a revision of this structure. The Resident Medical Superintendent has executive and administrative responsibilities as well as medical ones. His medical responsibilities include the treatment, care and custody of all patients in the hospital. Several powers and duties in regard to the reception, detention and discharge of patients are assigned to him by statute. There is provision for the assignment of these powers and duties to other medical officers and most Resident Medical Superintendents have divested themselves of as many unnecessary responsibilities as possible, so that they can devote more of their time to the treatment of patients. Originally the Resident Medical Superintendent was a person who lived in the hospital and accepted full responsibility for everything. This is an outmoded concept. Several Superintendents are no longer resident and it is unnecessary that they should be resident. Medical Superintendents are selected because of their ability as psychiatrists. It is most undesirable that they should have to accept responsibilities which can be undertaken by lay staff (see paragraph 191). It is also undesirable that they should have to accept clinical responsibility for treatment provided by competent and experienced colleagues of consultant status—a responsibility which cannot be discharged in a busy modern mental hospital. In most cases these difficulties are overcome by co-operation between the various people concerned, but the Commission considers that the matter should be placed on a firmer basis. There should be a psychiatrist in charge with overall responsibility for the organisation and operation of the hospital, but doctors of consultant status should have full clinical responsibility for their patients. Again the title " Senior Assistant Medical Officer" is undesirable; most of these officers are of consultant status, but the term " Assistant" suggests a subordinate role.

The term " Assistant Medical Officer " covers medical officers of different kinds. Some persons holding the post are newly qualified and lack experience or qualifications in psychiatry—others have qualifications and experience and should be regarded as psychiatrists. It appears to the Commission that this grade could suitably be divided to distinguish between those who are qualified and experienced and those who are in the training stage.

Hie Commission considers that a medical staff structure more closely resembling that in general hospitals should be developed. It suggests **mat this is a suitable matter for consideration by the National Advisory Council referred to in paragraph 187.**

Administrative and Clerical Staff

191. At present the Resident Medical Superintendent is the "person

in charge " of a district mental hospital and technically responsible for the administration of the hospital. The Secretary (or Chief Clerk) is nominally under his control, but the type of work the latter performs is such that the Resident Medical Superintendent is not in a position to exercise executive control over him. The Secretary controls the administrative staff such as the Assistant Clerk, Registrar, Clerk Typists and Storekeepers, Assistant Storekeepers etc., and he acts also as general adviser on administrative matters to the Resident Medical Superintendent and the medical staff. Since the early 1950's increased responsibilities have been assigned to Secretaries and Chief Clerks—in particular, responsibility for all the legislative and accounting work in the hospital. **It is most desirable that medical and nursing staff should be free to concentrate on the duties for which they are trained and that they should be relieved of work of an administrative nature which can be entrusted to lay staff. The Commission accordingly recommends that control of services such as laundries and cater. ing, building maintenance and repairs, heating and sanitation, should be assigned to a lay administrator.** It is vital, however, to remember that a hospital should be a therapeutic community and that the pattern and efficiency of these services have an important bearing on the mental health of the patients. **It is essential, therefore, to maintain close liaison between the lay administrator and the medical and nursing staffs; and in all matters, the welfare of the patient must be the primary consideration.**

There should be sufficient clerical and typing staff to ensure that doctors are relieved, as far as possible, of work of a clerical nature.

Flexibility in the use of Nursing Staff

192. The Commission recommends in paragraph 63 that male and female patients should mix freely at recreation, at work and at meals, as they do in normal life. **It recommends also that the practice whereby male patients are always looked after by male nurses and female patients by female nurses should be reviewed.** It has been shown clearly in other countries and in some places in this country, that female nurses can provide psychiatric nursing for many male patients and that their presence in male wards has a most beneficial effect. A therapeutic psychiatric hospital aims at creating a home environment and should resemble a normal home; the presence of female nursing staff helps enormously to create such an environment.

While the Commission considers that female nurses have an essential part to play in the care and treatment of male patients, it considers that male nurses have still a very important part to play. For many male patients nursing care can most suitably be provided by male nurses. Many authorities accept that male nurses are often very suitable as group leaders, organisers of activity of various kinds, tutors and nurse-administrators. **In these fields they can provide services for both male and female patients and the** Commission **recommends that it should be made possible for them to do so.**

Nursing Staff Structure

193. With the increased integration of services for male and female patients, the Commission considers that all nurses, male and female, should be under the control of one person. At present there is a Matron in charge of all female nurses and a Head Male Nurse in charge of all male nurses. It is understood that in one hospital it is proposed to appoint a person who will have male and female deputies, but who will have overall responsibility for the nursing services of the hospital. **The Commission recommends that similar posts should be created in other hospitals. Competition for the posts should be open to suitable persons of either sex.**

At present, female applicants for posts as Matron or Deputy Matron, are required to be qualified in general nursing as well as in psychiatric nursing. This requirement dates from a time when psychiatric training was less adequate than it is to-day and when a qualification in general nursing was required as a means of ensuring that the most suitable candidate would be appointed. The Commission regards it as equally desirable that applicants for senior posts, male and female, should have adequate experience in group leadership and activation (see also paragraph 167). **The Commission considers that the requirement in relation to general nursing is no longer necessary and recommends that it should be withdrawn.**

Non-nursing Duties

194. The Commission considers that nurses, acting as leaders and activators, should participate with patients in any work or recreational activity which is directly related to the care and rehabilitation of patients. The Commission, however, considers that nurses should not be employed on domestic or service tasks which are not related directly to the care and rehabilitation of patients, even though they may be essential hospital services. **The Commission recommends that adequate non-nursing staff should be employed to ensure that nurses have not to undertake these duties.**

Hospital Committees

195. A good and harmonious relationship between the different members of the staff in a psychiatric hospital is essential to create the therapeutic atmosphere so necessary for the patients. The fostering of good relations is one of the main responsibilities of the psychiatrist in charge and, indeed, of every senior member of the staff—medical, nursing and lay. There are many ways in which good relationships can be fostered, but one of the most important is the development of continuous communication, so that all members of the staff are aware at all times of one another's aims and problems and that each feels he is part of a team to which he has a contribution to make. **There are many ways in which communications can be maintained, but the Commission considers that one of the most important is the development of committees at various**

levels; in particular the Commission considers that medical, nursing and joint committees are desirable.

In district mental hospitals the medical staff has been headed, traditionally, by the Resident Medical Superintendent whose position, if he desired so to use it, was that of an autocrat. In most hospitals the need for co-operation and team-work at medical level has been recognised. **The Commission considers, however, that the matter should be put on a regular basis and it recommends that, in each hospital, mere should be a Medical Committee of which all doctors on the staff would be members.** The Medical Committee should meet regularly to discuss all matters pertaining to the operation of the hospital and the care of patients. Where there is frank discussion and a spirit of good-will usually it will be found possible to reconcile the different views of members. When this is not possible, the views of the Superintendent would prevail as a rule. However, other members should have a means of putting forward their views directly, for consideration by the hospital authority.

The Commission recommends that mere should be a Nursing Committee of which all senior members of the nursing staff should be members. The function and method of operation of the Nursing Committee should be similar to that of the Medical Committee. In addition to the Nursing Committee there should be Divisional Committees, so that junior nursing staff also are given an opportunity of expressing their views.

All staff in a psychiatric hospital contribute towards the operation of the hospital and towards the treatment of patients. Team-work and co-operation are essential, not only at medical and nursing levels but at all levels. **The Commission recommends mat there should be a Joint Committee representative of medical, nursing and lay staff.** The Committee should meet regularly and discuss matters of common interest so that all views are taken into account before decisions are made.

Area Boundaries

196. Mental hospital districts follow county boundaries and little provision is made for treating a patient outside his own area, except as a matter of urgency. This results in anomalies, e.g. a person living in that part of Waterford City which is in the administrative area of County Kilkenny may have to attend for hospital treatment in Kilkenny City, which is 30 miles away, rather than in the City in which he resides. The proposals for regionalisation outlined in the White Paper on the Health Services and their Further Development will remove many of these anomalies. **It is very desirable, however, that patients should be able to obtain treatment with as little difficulty as possible and the Commission recommends that provision should be made so that it would be possible for patients, in appropriate cases, to obtain treatment outside the area in which they reside.**

Hospital Farms

197. Most district mental hospitals have substantial farms attached.

Originally these were intended to provide occupation and exercise for patients and to supply food which could not readily be obtained otherwise. They were relatively small until the 1930's and 1940's when many were substantially increased in size: at present they range from about 100 to nearly 1,000 acres. **The Commission recommends that the necessity for the retention of farms should be carefully reviewed.** It does not regard it as a function of health authorities to operate farms which may absorb much of the time and energies of available staff. It considers that farms should not be retained unless they serve as sheltered workshops or provide occupational therapy which cannot suitably be provided by other means, or unless they provide food which cannot be obtained by other means at a reasonable cost. **Where farms are retained, the Commission recommends that they should be operated as undertakings separate from the hospital.** If they are used as sheltered workshops, or for the purpose of providing occupational therapy, payments should be made in respect of the services provided by patients. The Commission considers that there is much more scope for the employment of patients if farms are used, as far as possible, for horticultural purposes. To some extent they could be used as model farms to teach patients new skills in farming operations.

Building Control

198. The Minister for Health usually pays a considerable part of the cost of buildings at health authority institutions. It is right that he should exercise reasonable control to ensure that satisfactory standards are maintained and that wasteful expenditure is avoided. The Commission, however, regards as cumbersome and slow the present procedure under which almost every building project has to be sanctioned and the plans for it approved in detail by die Minister. **Health authorities have considerable discretion in the spending of large sums of money in other fields and the Commission recommends that they should be allowed discretion also in regard to buildings. It recommends mat, as far as possible, the Minister should exercise control by the issue of general directives, by specifying standards to be adopted and by the preparation of standard plans which can be nsed, in suitable circumstances, by different health authorities.**

Organisation of Central Mental Hospital

199. At present the Central Mental Hospital is administered by the Minister for Health and the staff employed are Civil Servants. There are three medical posts and 63 permanent posts of attendant (excluding supervisory grades). These attendants are not qualified in psychiatric nursing or general nursing. There are Male and Female Head Attendants, both of whom are qualified nurses.

The Central Mental Hospital is relatively small—its capacity is about 140 patients. It is the only hospital administered by the Minister for Health—all district mental hospitals are administered

by health authorities. There is no provision for transfer of staff between district mental hospitals and the Central Mental Hospital. Consequently, staff vacancies arising from illness, holidays, etc., have to be filled by recruiting temporary staff, many of whom have little, if any, experience of psychiatry. The Central Mental Hospital is too small and the types of patients cared for are too limited to justify its use as a training centre for psychiatric nurses. Difficulty has been experienced in recruiting medical staff. Young doctors are not attracted to the hospital, as its range of activities is too limited to provide opportunity for a broad experience of psychiatry. The turnover of patients in the hospital is very small—only about 30 patients are admitted per year. Out-patient or domiciliary services are not provided and the activities of all members of the staff, therefore, are restricted to the in-patient care of a limited range of psychiatric illnesses. Even if better use is made of the Central Mental Hospital, as suggested in paragraphs 126, 129 and 131, most of these disadvantages will remain if the organisation of the Central Mental Hospital continues as at present. **The Commission recommends, therefore, mat the hospital should cease to be administered by the Minister for Health and that it should be administered, as is every district mental hospital, by the local health authority.** This would remove many of the drawbacks. It would enable the medical staff at the Central Mental Hospital to serve in other mental hospitals, to conduct clinics, to engage in other extra-mural psychiatric activities and, generally, to avoid the professional isolation which follows inevitably from the present organisation. It would also facilitate the provision of psychiatric nursing. **The Commission regards as unsatisfactory the present position whereby care of mentally ill persons is entrusted to attendants who are not qualified nurses, and it recommends that as soon as practicable attendants should be replaced by psychiatric nurses. It** is understood that there are usually about 20 posts filled by temporary attendants. It should be possible, as an immediate step, to create in lieu of these a number of permanent posts to be filled by psychiatric nurses. Recruitment of attendants should be discontinued and as vacancies arise they should be filled by psychiatric nurses. The attendants at present employed should be given an opportunity to undertake psychiatric nurse training. **The Commission recommends that the State should continue to pay the cost of maintaining custody patients, but that the appropriate health authority should pay the cost of maintaining other patients sent to the Central Mental Hospital.**

CHAPTER 10

LEGISLATION

General

200. As stated in paragraph 10, until 1945 the law relating to mental illness in Ireland was governed by a series of statutes passed mainly in the 19th century. In that year the Mental Treatment Act, 1945, was passed. This was a comprehensive measure and, as well as laying down precise admission and detention procedures, dealt with all aspects of the care and treatment of the mentally ill, other than criminal lunatics and wards of court. It provided, inter alia, for—

(i) the formation of mental hospital districts and the appointment of mental hospital authorities;

(ii) the duties of mental hospital authorities to provide hospitals, treatment, maintenance, advice and services;

(iii) the financing of mental hospital authorities;

(iv) the acquisition and disposal of land by mental hospital authorities;

(v) the superannuation of staff of mental hospital authorities.

Practically all of the listed provisions have been repealed and have been replaced by legislation applying to all health authorities and to health services generally. The Commission welcomes these changes as part of the process of integrating psychiatry and general medicine. The provisions made in the Mental Treatment Act, 1945, in regard to the reception and treatment of patients have been amended in some respects, but basically they remain the same. The original provisions were enlightened at the time the Act was passed; in particular, the provision for the reception of patients on medical certificate, without the intervention of a judicial authority, was a most desirable change which has now become the accepted procedure in many countries. However, thinking in regard to mental treatment has advanced considerably in the past twenty years and the Commission considers that the changes outlined in the following paragraphs are now necessary.

The changes proposed in this chapter are framed in general terms as the Commission considers that the specific legal terminology required to give effect to its recommendations on legislation could be provided more appropriately by Parliamentary Draftsmen.

(a) THE RECEPTION AND DETENTION OF PATIENTS

Present Provisions

201. Under the law in force at present, patients received into mental hospitals are admitted as voluntary patients, temporary patients or persons of unsound mind. The procedures for admission, discharge etc. vary in detail within each category, but, in broad outline, they follow the following pattern :—

Voluntary patients enter and receive treatment of their own free will and are admitted with the minimum of formality. If the person in charge of the hospital agrees that treatment is required, the patient completes a simple written application. The procedure varies slightly in the case of a person under 16 years; here, application is made by the parent or guardian and must be accompanied by a recommendation from a registered medical practitioner stating that he has examined the patient on a specified date not more than seven days before the date of the appliction and that, in his opinion, the patient will benefit by the proposed reception.

A voluntary patient may give notice that he wishes to leave the hospital, and he must then be allowed to do so on or after the expiration of 72 hours. If the patient is under 16 years, the notice must be given by the parent or guardian, who is then entitled to remove the patient forthwith.

Temporary patients are admitted and detained on a compulsory basis. Broadly speaking, they are (a) persons who require to be detained for treatment but who are believed to require no more than six months suitable treatment for recovery, or (b) addicts who, by reason of addiction to drugs or intoxicants, require compulsory detention. Application for admission is made by a near relative, the assistance officer, or, in certain circumstances, any interested person. The application must be accompanied by a medical certificate to the effect that the patient is suffering from mental illness, or is an addict, and requires treatment; in the case of private patients this certificate must be signed by two doctors.

In the first instance a temporary patient may not be detained for longer than six months, but this period may be extended in certain cases.

Persons of Unsound Mind are also admitted and detained on a compulsory basis. Broadly speaking, they are patients who require detention and who are unlikely to recover within six months. The admission procedure followed is much the same as that for temporary patients. Persons of unsound mind may be detained for an indefinite period.

A detained patient who is not dangerous to himself or others may be allowed absence on parole for a period not exceeding 48 hours. A patient may be permitted to absent himself on trial for periods up to 90 days. A temporary patient or a person of

unsound mind who leaves the hospital without permission may be brought back to hospital within 28 days.

Informal Admission

202. The provision for voluntary admission in the Mental Treatment Act, 1945, encouraged many patients to come at an early stage when their illness was more susceptible to treatment and the proportion dealt with on a voluntary basis has increased steadily over the years. This increase has raised no problems for those responsible for the administration of mental hospitals. On the contrary, it has enabled them to dispense with many restrictions on personal liberty which formerly were deemed necessary. The process has been carried a stage further in some countries where it is now thought that mentally ill patients should be admitted to and treated in hospital with as little formality as possible—on much the same basis as patients suffering from physical illness. The Commission fully accepts this view.

Under the present law a person who wishes to enter hospital as a voluntary patient is required to sign a statutory form of application for admission to hospital. Inj addition, an adult patient may not be admitted as a voluntary patient unless his mental condition is such that, at the time, he is able to express a wish to avail himself of hospital treatment. Such statutory procedures do not apply in the case of general hospitals and they may deter some mentally ill patients from seeking treatment.

The Commission considers that the procedures outlined are unnecessary in most cases. The difficulties involved could be overcome simply by admitting a patient without legal formality if he or his relatives raise no positive objection. It should be assumed that the patient is willing to accept treatment, even though he may not be mentally capable of consenting to do so. This is what is done in a general hospital when a patient gravely ill or unconscious, e.g. as a result of a car accident, is brought in for treatment. Even though he is not capable at the time of exercising his right to accept or refuse treatment, he is regarded as being willing to accept the treatment deemed appropriate by the competent medical officers present.

The Commission therefore recommends that it should be possible to admit patients informally **as is done in general hospitals.** In the absence of positive objection by the patient or the patient's relatives, it should be assumed that the patient is willing to accept the regimen of the hospital and any treatments provided. As a general rule, patients admitted informally should have the right to leave the hospital at any time on request. For practical reasons this right must be subject to some limitation. A patient undergoing a temporary phase of mental disturbance during the course of treatment might express a wish to leave the hospital, or, having left the hospital on temporary approved absence, might decide not to return. In some such cases, to ensure the patient's safety or the safety of others, it will be necessary to give the hospital authority the right of detention until it can

communicate with the relative of the patient who would normally accept responsibility for him on his discharge from hospital. In such cases a doctor on the staff of the hospital should be able to issue a certificate certifying that it is essential to detain the patient for his own safety or the safety of others. The certificate should permit the hospital authority to detain the patient for 72 hours or such lesser period as may be necessary to make alternative arrangements for his care. The power of detention should apply to patients whether they are in the hospital or temporarily outside it.

A register of all patients admitted informally should be kept in every mental hospital or psychiatric unit. In order to avoid overstating the number of admissions for statistical purposes, an informally admitted patient who leaves the hospital with the approval of the staff, e.g. to visit his home at week-ends, should not be treated as a separate admission on returning to hospital.

Compulsory Admission and Detention

203. The Commission considers that most psychiatric patients who require residential treatment can be admitted under the informal procedure discussed in paragraph 202. There is, however, a small minority of patients for whom powers of compulsory admission and detention will be necessary in order to protect their own interests or the interests of other persons. The Commission considers that, in general, the use of compulsory powers can be justified only where the patient's mental illness is of such a degree :—

(a) that detention and treatment in hospital are necessary in the interests of the patient's health and safety or for the protection of other persons; and

(b) that the patient is not prepared to accept, or is not suitable for, treatment on an informal basis.

The Commission wishes to stress its view that compulsory powers should be used only as a last resort, e.g. when positive efforts to persuade the patient to accept treatment voluntarily have failed.

The Commission recommends the adoption of a procedure on the following lines in cases where compulsory admission and detention are necessary. The application for admission and detention should be made by a relative, or other suitable person; it should be accompanied by a certificate from a registered medical practitioner stating that he has examined the patient and, as a result, is of opinion that he needs treatment in a psychiatric hospital. The certificate should state clearly the grounds on which the opinion is based. This certificate should be sufficient authority to have the patient brought to a psychiatric hospital for examination by an authorised member of the medical staff, who, if satisfied on preliminary examination that residential treatment is necessary and **cannot be provided suitably on an informal basis,** should certify

accordingly. This certificate would authorise the admission of the patient to hospital and his detention for an initial period not exceeding 14 days. As soon as possible after admission, but in any event before the expiry of 14 days, the patient's condition should be thoroughly investigated by an authorised medical officer of consultant status, who could authorise the patient's detention for a further period not exceeding 6 weeks from the date of admission. According to the requirements of the patient's treatment, detention could be further extended, in the first instance for a period not exceeding three months from the date of admission, and subsequently for periods not exceeding twelve months on any one extension. Extensions following the initial periods of 14 days and 6 weeks should be on the basis of certificates signed by two authorised medical officers, at least one of whom should be a psychiatrist approved by the Minister for Health for this purpose. Each medical officer should be required to record on the certificate the reasons why he is satisfied that a further period of detention is necessary.

The Commission appreciates that, in some instances, it may be clear that detention over a long period will be required and that it could be contended that the issue of yearly certificates would not be necessary. It is essential, however, to review the condition of all patients at regular intervals and the Commission considers, therefore, that the issue of yearly certificates should not create any unnecessary work.

The procedure proposed may give rise to difficulty when a patient refuses to undergo the initial medical examination, or where a medical practitioner is not readily available, or where the patient refuses to go to hospital, or where a relative willing to apply to have him admitted to hospital cannot be traced. **The Commission recommends that, to provide for such cases, provisions similar to those in sections 165 and 166* of the Mental Treatment Act, 1945, as amended, should be incorporated in the new legislation. The penalty for obstruction (section 166 (4» should be increased.**

A register of all patients admitted and detained compulsorily should be maintained in every mental hospital or psychiatric unit. The new provisions should apply to all patients already in hospital (either " voluntary " or "detained "); each should be deemed to have been admitted informally unless an extension certificate is made. To provide time for consideration of each case, there should be a transition period during which the patients can be detained under existing powers.

Remedies for Improper Detention

204. The principal remedies for any possible improper detention of patients are :—

•Sections 165 and 166 deal with the powers of theGardaiSiochana and Assistance Officers to apply for a recommendation to receive into a mental hospital persons believed to be of unsound mind and not under proper care.

(1) Habeas Corpus—the patient, or someone acting on his behalf, may apply to the High Court for an order that he be released on the ground that he is being unlawfully detained.

(2) Any person may apply to the Minister for Health for an Order for the examination of a detained patient by two medical practitioners, and the Minister on consideration of their report, if he thinks fit, may direct the discharge of the patient.

(3) The Inspector of Mental Hospitals must visit all mental hospitals at stated intervals, and he has a duty to give special attention to the state of mind of any patient detained where the propriety of detention is doubtful, or when he is requested by the patient, or by any other person, to do so. The Inspector must also ascertain whether the periods of detention of any temporary patients have been extended since his previous visit; and, if so, he must give particular attention to the patients concerned.

(4) Any relative or friend of a person detained may make application for the discharge of a patient to his care. The application must be granted unless the medical officer of the hospital certifies that the patient is dangerous or otherwise unfit for discharge, in which event an appeal against refusal of the application lies to the Minister.

(5) Every mental hospital authority must appoint a visiting committee, whose duties include that of hearing the complaints of any patient. If requested to do so, they must see the patient in private.

(6) When the chief medical officer of a hospital extends the period of detention of a temporary patient, he must advise the patient and the applicant for the original reception order that either of them can send to the Inspector of Mental Hospitals an objection to the extension. On receipt of an objection, the Inspector must take such steps as he deems necessary to satisfy himself of the propriety or otherwise of the continued detention of the patient. If he feels that the patient should not be detained further, he must report the fact to the Minister, who may order the discharge of the patient.

(7) Every patient has the right to have a letter forwarded, unopened, to the Minister for Health, the President of the High Court, the Registrar of Wards of Court, the Mental Hospital Authority, a Visiting Committee of a District Mental Hospital or the Inspector of Mental Hospitals. The Minister may arrange for an examination of a patient by the Inspector of Mental Hospitals and may direct his discharge where justified. The President of the High Court may require the Inspector to visit and examine any patient detained as a person of unsound mind and to report to him.

(8) It is specifically required that a patient who has recovered must be discharged.

(9) Penalties are imposed by the Act for detention otherwise than in accordance with the provisions of the Act.

The Commission is not aware of any evidence of public disquiet about the effectiveness of the remedies for improper detention now available. They appear to have worked well and the Commission considers them adequate. Some technical amendment will of course be necessary in the light of the changes of procedure the Commission has recommended.

(b) THE REGISTRATION OF RESIDENTIAL CENTRES FOR THE MENTALLY I I I

Present Provisions

205. Mental hospitals and homes under private management which cater for mentally ill patients are divided into four classes as follows:—

(1) Private charitable institutions, i.e. institutions for the care of persons of unsound mind which are supported wholly or in part by voluntary contributions, which are not kept for profit by any private individual and which are not (a) district mental hospitals or other institutions maintained by mental hospital authorities, or (b) authorised institutions (See (4) below).

(2) Private institutions, i.e. institutions or premises in which one or more than one person of unsound mind is or are taken care of for profit and which are not (a) district mental hospitals or other institutions maintained by mental hospital authorities ; (b) private charitable institutions ; or (c) authorised institutions.

(3) Approved institutions, i.e. institutions or premises approved by the Minister by Order under section 158 of the Mental Treatment Act as institutions or premises for the reception **of** temporary and/or voluntary patients.

(4) Authorised institutions, i.e. institutions authorised by special Act or other enactment (including a Charter) for the care, maintenance and treatment of persons of unsound mind and not being the Central Mental Hospital.

There are only technical differences between the four classes and, for practical purposes, the private mental hospitals and homes are treated to a very large extent as a homogeneous group notwithstanding the very wide differences in the scope and nature of their activities.

Proposed Provisions

206. The Commission considers that this classification system is unnecessarily cumbersome and recommends that in future centres for the mentally ill be classified as psychiatric hospitals or as psychiatric nursing homes, according to the type of service provided (see paragraphs 70 and 71). In addition, under the extended services recommended in this Report provision will be required for hostel accommodation (see paragraph 81). All such hospitals, homes or hostels should be registered in a register to be maintained by the Minister for Health and it should be an offence to provide psychiatric care and treatment on a residential basis for mentally ill persons in return for payment except in duly registered hospitals, homes or hostels. An exception should be made in the case of mentally ill persons boarded out in family care. All registered premises should be subject to inspection by the Inspector of Mental Hospitals, but the Minister for Health should be empowered to except particular centres from such inspections. Exemptions however, should not be granted in respect of centres which detain, or propose to detain, patients compulsorily. An exemption could, of course, be withdrawn if it subsequently emerged that there were reasonable grounds to assume that patients were, in fact, being detained. The Commission considers that provision for inspection at least once a year would be adequate.

(c) GENERAL

Sheltered Employment

207. Health authorities should have power to provide, or to arrange for the provision of, sheltered employment for persons who are either mentally ill or recovering from mental ilhiess. When sheltered employment is provided by voluntary agencies health authorities should be given powers of inspection to ensure that the needs of the persons employed are being adequately met and that appropriate standards are being maintained.

Wards of Court

208. The High Court has succeeded to the lunacy jurisdiction formerly delegated by the Crown to the Lord Chancellors, a jurisdiction which was extended and modified by the Lunacy Regulation (Ireland) Act, 1871. This jurisdiction is exercisable by the President of the High Court or by some other Judge of the High Court to whom is may be assigned by him. The Circuit Court exercises a similar jurisdiction under the County Court Jurisdiction in Lunacy (Ireland) Act, 1880, and the Courts (Supplemental Provisions) Act,

1961, in cases in which the value of the property of the person in question is below certain limits fixed by these Acts.

Section 283 (2) of the Mental Treatment Act, 1945, provides that no power, restriction or prohibition contained in the Act shall apply in relation to a person of unsound mind under the care of a Judge of the High Court or of a Judge of the Circuit Court. The fact that a Ward of Court cannot be admitted to a mental hospital under the provisions of the Mental Treatment Act, 1945, gives rise to serious difficulties. An application to have a person admitted to a mental hospital may have to be made by someone who cannot be expected to know whether he is a Ward of Court or not. As matters stand at present, an application for the admission to a mental hospital of a person whose past history the applicant does not know may result in an illegal detention. The Commission considers that the law should be amended so as to make it lawful for a Ward of Court to be admitted to a mental hospital either under a Court Order or under the statutory provisions applicable to persons who are not Wards of Court. The Commission also thinks it undesirable that mental hospital authorities should have no power to allow Wards of Court out on parole or on trial or to discharge them without the leave of the Court. Restrictions of this kind tend to perpetuate the idea that mental hospitals are primarily places of detention. **The Commission accordingly recommends that the law be changed so as to allow mental hospital authorities as much freedom as possible in dealing with patients who are Wards of Court, subject only to such control by the Court as may be considered necessary.**

Designation of Mental Hospitals

209. Under existing legislation public mental hospitals are formally designated as district mental hospitals, auxiliary mental hospitals or branch mental hospitals. The Commission considers that the designation of psychiatric units in general hospitals by any of these titles would be undesirable and unnecessary. **It recommends that provisions in existing legislation requiring the formal designation of hospitals providing psychiatric treatment should be repealed.**

Boarding Out in Family Care

210. The existing scheme of boarding out in family care for detained mentally ill patients is described in paragraph 78. The Commission recommended in paragraph 80 that provision for a less restricted form of boarding out should be made in the future —in particular the requirement that only one patient can be boarded out in any one dwelling should be removed. **The legislation recommended in this Chapter should include provisions to give effect to these recommendations.**

Transfer of Certain Patients to the Central Mental Hospital, Dundrum

211. The Commission recommends in paragraph 129 thai the procedure under which homicidal and very violent patients are transferred from district mental hospitals should be changed to one of medical certification. **Legislation will be necessary to give effect to the recommendations in that paragraph.**

Absence with Permission

212. Under existing legislation detained patients may be allowed to be absent from hospital on "parole" for periods not exceeding 48 hours and to be absent on trial for periods up to 90 days. **The Commission recommends that these provisions be replaced by one allowing " absence with permission " for periods up to 90 days. Any detained patient who has completed 90 days permitted absence should be discharged.**

CONCLUSION

213. We wish to express our appreciation of the great help which we received from our Secretary, Mr. C. Mulvihill. The requirements of the Commission necessitated his working at high pressure on numerous occasions, but he was invariably cheerful and optimistic and he showed most exceptional skill and energy in drafting the report and in dealing with all the arduous tasks entrusted to him. We owe him a very special debt of gratitude for his unfailing and friendly co-operation with us at all times.

Mr. Mulvihill was ably assisted by Mr. O. Hogan who acted as his deputy on various occasions, by Mr. S. Murphy who gave considerable help in finalising the report and by Miss M. Brady and Miss J. Blehein who arranged most of our meetings, visits, travel and accommodation requirements. We are most grateful to them all for their help.

We are also grateful to the staff of the Department of Health which furnished us with any information we required and assisted us in various ways. We are particularly appreciative of the splendid service provided by the Typing Section throughout our Inquiry.

Finally, two members of the Commission, Mr. J. J. Darby and Dr. B. MacM. Ramsay, both of the Department of Health, must be especially thanked by their fellow-members for the amount of **work they put** into **the** compilation of this Report and for the many ways in which they helped with their wide knowledge and experience of **the** problems involved.

Signed

Seamus Henchy (Chairman)

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M. Viney

C J. Mulvihill (Secretary)

1st July, 1966.

APPENDIX A

MEMBERS OF THE COMMISSION

The Hon. Mr. Justice Henchy *(Chairman).*
Leslie Bean de Barra.
J. C. Barrett, Esq.
J. F. Carroll, Esq.
Mrs. E. Crowley, S.R.N., R.M.N., S.C.M., R.F.N.
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E. Timmons, Esq., P.C.
M. Viney, Esq.
C. J. Mulvihill, Esq. *(Secretary).*

The following members of the Commission died : (1) N. J. Burke, Esq., 8th April, 1965; (2) V. G. Crotty, Esq., M.B., B.Ch., B.A.O, D.P.M., 13th December, 1964.

The following members resigned : (1) The Hon. Mr. Justice Martin C Maguire, 19th September, 1962; (2) Rev. J. Erraught, S.J., 2nd April, 1963; (3) L. G. Kiloh, Esq., B.Sc., M.D., D.P.M., 1st October, 1962; (4) J. P. McCann, Esq.. L.R.C.P.I., 20th September, 1962.

The following members were appointed after the establishment of the Commission: (1) The Hon. Mr. Justice Henchy, 24th September, 1962; (2) J. V. Glass. Esq.. M.B.. B.Ch., B.A.O., D.P.M., 2nd June, 1965; (3) M. B. Holohan, Esq., M.B. B.Ch.. B.A.O., 10th December. 1962; (4) D. W. K. Kay. Esq.. M.A.. D.M.. D.P.M., 7th August, 1963; (5) L. G. Kiloh, Esq., B.Sc., M.D., D.P.M., 8th February, 1962; (6) M. Viney, Esq., 16th July, 1965.

APPENDDC B

LIST OF WITNESSES

(1) National Organisation for Rehabilitation—represented by Dr. T. Gregg, Medical Director, and Mr. C. Sweeney, Secretary.
(2) District Justice E. O'Riain.
(3) Royal Medico Psychological Association (Irish Division)—represented by
Dr. C. B. Robinson
(Purdysburn Hospital, Belfast), Chairman, Irish Division;
Professor John Dunne,
Professor of Psychiatry, University College, Dublin;
Dr. Desmond McGrath,
Medical Director, St. John of God Psychiatric Hospital, Stillorgan;
Dr. John Hill, R.M.S.,
District Mental Hospital, Portlaoise, and
Dr. Mary Sullivan,
Verville Retreat, Clontarf, Dublin; Secretary, Irish Division;
(4) Dr. D. Walsh,
St. Loman's Hospital, Ballyowen, Dublin.

APPENDIX C

ORGANISATIONS AND PERSONS WHO SUBMITTED MEMORANDA OF EVIDENCE

(1) Dr. T. F. Armstrong.
(2) Association of Parents and Friends of Autistic Children.
(3) Miss Cecilia Barrett.
(4) Miss E. M. Bergin.
(5) An Bord Altranais.
(6) Mr. Patrick Byrnes.
(7) Mr. Con Callanan.
(8) Carlow-Kildare Mental Health Board.
(9) Mrs. Mary Casserly.
(10) Dr. P. J. Cassin.
(11) Catholic Women's Federation of Secondary School Unions.
(12) Cavan-Monaghan Mental Health Board.
(13) Dr. J. J. Clarke.
(14) Mr. Daniel Cronin.
(15) Mr. Myles Dockrell.
(16) Mr. T. P. Gillie.
(17) Miss Myrtle Glass.
(18) Mr. James Haire, M.P.S.I.

(19) Dr. B. F. Honan.
(20) Irish Countrywomen's Association.
(21) Irish Medical Association.
(22) The Irish Nurses' Organisation.
(23) Messrs. J. T. Kavanagh and E. Nangle.
(24) Mr. Bartley Keane.
(25) Longford-Meath-Westmeath Mental Health Board.
(26) Miss Brigid McDonald.
(27) Miss Maud McKenna.
(28) Mr. Stephen McLoughlin.
(29) Mr. D. P. Murphy.
(30) Mrs. Bridget O'Callaghan.
(31) Mr. John O'Connor.
(32) Dr. J. H. O'Donnell.
(33) Mrs. K. O'Gara.
(34) Seamus S. 6 Ghormleaghaigh, Uas.
(35) Mrs. Mary O'Grady.
(36) Mr. Michael O'Meara.
(37) National Organisation for Rehabilitation.
(38) Rev. Dr. J. G. O'Neill.
(39) Mr. Ignatius O'Rourke.
(40) District Justice E. O'Riain.
(41) Dr. E. N. M. O'SulKvan.
(42) Dr. P. J. Power.
(43) The Rehabilitation Institution.
(44) Royal Medico-Psychological Association (Irish Division).
(45) Mr. K. Ryan.
(46) Dr. J. R. Shea.
(47) Society of Medical Officers of Health.
(48) Southern Members of Irish Region of British Association of Psychiatric Social Workers.
(49) Miss K. Sweeney.
(50) Dr. Dermot Walsh.
(51) Waterford Health Authority.

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APPENDIX E.

List of Health Authorities Administering Mental Hospitals.

Health Authority (County Council unless otherwise stated)	District Served	1961 Population	Hospital	Number of patients on Register on 31/12/1965
Louth	County Louth	67,378	Ardee	356
Galway-Roscommon Mental Health Board	Counties Galway and Roscommon	149,887 59,217	Ballinasloe .. Castlerea ..	1,575 404
Carlow-Kildare Mental Health Board	Counties Carlow and Kildare	33,342 64,420	Carlow	390
Mayo	Co. Mayo	123,330	Castlebar	1,022
Tipyerary Mental Health Board	Co. Tipperary	123,822	Clonmel	698
Cork	Cork City and County	330,443	Our Lady's Hospital, Cork *St. Raphael's Hospital, Youghal	2,235
Clare	Co. Clare	73,702	Ennis	625
Wexford	Co. Wexford ..	83,308	Enniscorthy ..	453
Dublin	Dublin City and County and Co. Wicklow	718,332	Grangegorman Ballyowen Portrane	3,553
Kilkenny	Co. Kilkenny	61,668	Kilkenny	427
Kerry	Co. Kerry	116,458	Killarney	830
Donegal	Co. Donegal	113,842	Letterkenny ..	614
Limeiick	Limerick City and County	133,339	Limerick	855
Cavan-Monaghan Mental Health Board	Counties Cavan and Monaghan	56,594 47,088	Monaghan ..	749
Longford-Meath-Westmeath Mental Health Board	Counties Longford Meath and Westmeath	30,643 65,122 52,861	Mullingar	988
Laois-Offaly Mental Health Board	Counties Laois and Offaly	45,069 51,533	Portlaois	596
Lcitrim-Sligo Mental Health Board	Counties Leitrim and Sligo	33,470 53,561	Sligo	710
Waterford	Waterford City and County	71,439	Waterford ..	504
Wicklow	Co. Wicklow ..	58,473	Newcastle	Nil to be opened at an early date

•Patients are not at present admitted directly to this hospital.

APPENDIX F

Approved Staffing Establishments—District ***Mental*** *Hospitals* **1/6/1966**

•Resident Medical Superintendent (On 1/6/1966, 20 were filled by permanent officers and 1 by a Senior Assistant Medical Officer in an acting capacity)	21
Senior Assistant Medical Officer .. (On 1/6/1966, 29 were filled by permanent officers,7 by Assistant Medical Officers in an acting capacity and 6 posts were vacant)	42
Assistant Medical Officer (On 1/6/1966, 30 were filled by permanent officers, 32 by temporary officers and 6 were vacant)	68
House Physician. . . . . (Training posts normally held for short periods—all were filled on 1/6/1966)	12
Matron	23
Deputy Matron.	28
Head Nurse	20
Deputy Head Nurse	25
Head Night Nurse (M) .. .	17
„ „ (F) .. .	19
Deputy Head Night Nurse (M) ..	18
„ „ „ (F) ..	21
Psychiatric Social Worker	2
Compounder	9
Visiting Dentist.	22
Anaesthetist	4
Charge and Deputy Charge Nurse	510
Ward and Deputy Ward Sister ..	449
General Trained Nurse .	141
Psychiatric Nurse and Trainee	2,795
Physiotherapist	2
Occupational Therapist .. .	11
Visiting Chiropodist .	11
Radiographer	2
Nurse for Mentally Handicapped	2
Outpatient Nurse	8
Sick Children's Nurse	2
Visiting Psychologist	3
Visiting Ophthalmic Surgeon	2
Visiting Speech Therapist ...	2

•The title Resident Medical Superintendent includes :

1 Medical Superintendent, St. Ita's Hospital, Portrane.

1 Medical Superintendent, St. Loman's Hospital, Ballyowen.

DISTRICT MENTAL HOSPITALS—*Out-Patient Clinics*

***Year ended* 31tf *March,* 1965**

APPENDIX G

District Mental Hospital	Popula-tion served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Number of Attendances
					Grand Total	Grand Total
St. Brigid's Hospital, Ardee, County Louth.	67,378	(i) St. Joseph's, Ardee	Weekly		123	531
		(ii) Drogheda	Weekly	15 Miles	196	1,116
		(iii) Dundalk	Weekly	13 „	302	1,752
		(iv) Carlingford	Alternate Weeks	27 „	42	120
		(v) Dundalk (Children's)	Weekly	13 „	50	264
					713	3,783
St. Brigid's Hospital, Ballinasloe, County Galway.	149,887	(i) Portiuncula Hospital	Twice monthly		109	259
		(ii) Bealadangan	Monthly	70 Miles	19	60
		(iii) Clifden	Monthly	90 „	31	96
		(iv) St. Brigid's Hospital Ballinasloe.	Monday-Friday (5 days weekly).	—	108	390
		(v) Regional Hospital, Galway.	Weekly	40 „	116	204
		(vi) Shantalla, Galway	Weekly	40 „	240	924
		(vii) Tuam	Weekly	33 „	140	504
		(viii) Gort	Twice monthly	34 „	57	195
		(ix) Portumna	Twice monthly	20 „	54	154
					874	2,786
St. Patrick's Hospital, Castlerea, County Roscommon.	**59,217**	(i) Castlerea	Daily	—	684	1,172
		(ii) Boyle	Fortnightly	19 Miles	563	883
		(iii) Roscommon	Fortnightly	19 „	599	904
		(iv) Strokestown	Fortnightly	18 „	447	968
		(v) Ballaghaderreen	Fortnightly	12 „	299	507
					2,592	4,434

District Mental Hospital	Population served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Number of Attendances
					Grand Total	Grand Total
St. Dympna's Hospital, Carlow	97,762	(i) St. Vincent's, Athy	Weekly	12 Miles	135	481
		(ii) District Hospital, Muinebeag.	Twice monthly	10 „	94	346
Carlow 33,342		(iii) Carbury	Twice monthly	44 „	119	297
Kildare 64,420		(iv) Bonis	Twice monthly	18 „	51	194
		(v) Monasterevan	Twice monthly	24 „	99	294
(Carlow/Kildare Mental Health Board).		(vi) Carlow	Twice monthly	—	77	293
		(vii) County Hospital, Naas	Weekly	31 „	318	914
		(viii) Tullow Hospital	Twice monthly	8 „	82	349
					975	3,168
St. Mary's Hospital, Castlebar, County Mayo.	123,330	(i) Castlebar	Twice monthly		118	356
		(ii) Ballina	Twice monthly	22 Miles	152	515
		(iii) Belmullet	Monthly	48 „	137	345
		(iv) Claremorris	Monthly	17 „	111	395
		(v) Swinford	Monthly	18 „	82	294
		(vi) Achill	Monthly	32 „	95	462
					695	2,367
St. Luke's Hospital Clonmel, County Tipperary.	123,822	(i) Tipperary	Twice monthly	24 Miles	78	304
		(ii) Carrick-on-Suir	Monthly	13 „	67	169
		(iii) Thurles	Monthly	28 „	293	320
		(iv) Cashel	Monthly	15 „	53	147
		(v) Clogheen	Monthly	16 „	23	115
		(vi) Clonmel	Weekly	—	150	503
		(vii) Nenagh	Twice monthly	50 „	190	462
		(viii) Roscrea	Monthly	49 „	22	116
					876	2,136

District Mental Hospital	Popula-tion served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Grand Total	Number of Attendances	Grand Total
Our Lady's Hospital, Cork and St. Raphael's, Youghal, County Cork.	330,443	(i) St. Anne's, Cork	Daily		805		5,806	
		(ii) Mallow	Monthly	22 „	76		275	
		(iii) Clonakilty	Monthly	33 „	32		117	
		(iv) Youghal	Monthly	31 „	47		141	
		(v) Fermoy	Monthly	23 „	78		342	
		(vi) Bantry	Monthly	56 „	45		123	
		(vii) Castletownbere	Monthly	83 „	26		74	
		(viii) Macroom	Monthly	23 „	69		221	
		(ix) Bandon	Monthly	20 „	51		224	
		(x) Kanturk	Monthly	35 „	72		309	
		(xi) Dunmanway	Monthly	37 „	59		145	
		(xii) Skibbereen	Monthly	53 „	72		230	
		(xiii) Midleton	Monthly	14 „	65		176	
		(xiv) North Infirmary, Cork	Weekly	2 „	212		824	
						1,709		9,007
Our Lady's Hospital, Ennis, County Clare.	73,702	(i) Kilrush	Twice monthly	27 „	367		749	
		(ii) Bindon Street, Ennis	Monthly		134		208	
		(iii) Raheen	Monthly	23 „	100		208	
		(iv) Ennistymon	Monthly	17 „	139		218	
		(v) Our Lady's Hospital, Ennis	Three times weekly		209		627	
						949		2,010
St. Senan's Hospital, Enniscorthy, County Wexford.	83,308	(i) Enniscorthy	Weekly		241		1,370	
		(ii) Wexford	Weekly	15 Miles	351		1,271	
						592		2,641

District Mental Hospital	Popula-tion served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Grand Total	Number of Attendances	Grand Total
St. Brendan's Hospital, Grangegorman, Dublin.	776,805	(i) St. Brendan's Hospital, Grangegorman.	31 per fortnight	-	1,148		9,557	
		(ii) Crumlin	2 weekly		175		1,517	
Dublin 718,332		(iii) Mercer's Hospital	2 weekly	All in the	195		1,083	
*Wicklow 58,473		(iv) Dun Laoghaire	2 weekly	greater	82		590	
		(v) Ballyfermot	2 weekly	Dublin	786		1,082	
		(vi) St. Loman's	1 weekly	area.	2,636		2,970	
		(vii) Finglas	2 weekly		123		299	
		(viii) Killester (opened 24/2/65)	2 monthly	-	4		4	
		(ix) Balbriggan	2 monthly	20 Miles	51		279	
						5,200		17,381
St. Canice's Hospital, Kilkenny.	61,668	(i) Kilkenny County Health Clinic.	Twice weekly	—	484		1,050	
		(ii) Castlecomer District Hospital.	Twice monthly	12 Miles	57		63	
		(iii) Mullinavat	Twice monthly	22 „	36		61	
		(iv) Rosbercon	Twice monthly	27 „	44		73	
		(v) Thomastown	Twice monthly	11 „	35		127	
		(vi) Callan	Twice monthly	10 „	15		56	
		(vii) St. Canice's Hospital, Kilkenny.	As required		85		696	
						756		2,126
St. Finan's Hospital, Killarney, County Kerry.	116,458	(i) Tralee	Three per week	20 Miles	339		2,395	
		(ii) Listowel	Weekly	37 „	242		1,510	
		(iii) Killarney	Weekly	—	173		1,134	
		(iv) Dingle	Weekly	41 „	109		895	
		(v) Kenmare	Weekly	21 „	117		598	
		(vi) Cahirciveen	Weekly	39 „	231		1,059	
						1,211		- 7,591

*On 31st March, 1965, Wicklow patients were still catered for in Dublin.

District Mental Hospital	Population served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Grand Total	Number of Attendances	Grand Total
St. Conal's Hospital, Letterkenny, County Donegal.	113,842	(i) Letterkenny County Hospital	Twice monthly		163		506	
		(ii) Buncrana	Twice monthly	29 Miles	62		223	
		(iii) Carndonagh	Twice monthly	48 „	95		322	
		(iv) Dungloe	Twice monthly	32 „	79		242	
		(v) Donegal	Monthly	32 „	38		87	
		(vi) Ballyshannon	Monthly	47 „	52		119	
		(vii) Glenties	Monthly	28 „	53		149	
		(viii) Killybegs	Monthly	50 „	48		141	
		(ix) Milford	Monthly	12 „	42		132	
		(x) Falcarragh	Monthly	26 „	49		151	
						681		2,072
St. Joseph's Hospital, Limerick.	133,339	(i) Foynes	Twice monthly	16 Miles	201		217	
		(ii) Kilmallock	Twice monthly	21 „	271		329	
		(iii) Hospital	Twice monthly	17 „	366		388	
		(iv) Newcastlewest	Twice monthly	26 „	755		822	
		(v) Limerick	Weekly	—	1,567		1,751	
		(vi) Croom	Twice monthly	12 „	78		89	
		(vii) Doon	Twice monthly	14 „	108		123	
						3,346		3,719
St. Davnet's Hospital, Monaghan.	103,682	(i) Bailieboro	Twice monthly	30 Miles	133		757	
		(ii) Ballyjamesduff	Twice monthly	42 „	53		204	
		(iii) Carrickmacross	Twice monthly	26 „	101		611	
Cavan 56,594		(iv) Cavan	Weekly	30 „	273		1,442	
Monaghan 47,088		(v) Clones	Monthly	13 „	43		118	
		(vi) Monaghan County Hospital,	Weekly		166		909	
		(vii) St. Davnet's Hospital	by arrangement	—	142		910	
						911		4,951

District Mental Hospital	Popula-tion served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Grand Total	Number of Attendances	Grand Total
St. Loman's Hospital, Mullingar, County Westmeath.	148,626	(i) Longford	Weekly	27 Miles	181		624	
		(ii) Mullingar	Weekly		203		772	
		(iii) Navan	Weekly	36 „	261		972	
		(iv) Granard	Twice monthly	26 „	47		169	
		(v) Athlone	Weekly	29 „	119		503	
		(vi) Oldcastle	Twice monthly	23 „	32		116	
		*(vii) St. Loman's Hospital, Mullingar	Weekly		3		3	
Longford 30,643						846		3,159
Meath 65,122								
Westmeath 52,861								
St. Fintan's Hospital, Portlaoise (Laois).	96,602	(i) Tullamore	Twice monthly	22 Miles	76		639	
		(ii) Portlaoise (County Clinic),	Twice monthly		65		347	
		(iii) Birr	Monthly	37 „	79		165	
		(iv) Edenderry	Monthly	28 „	37		107	
		(v) St. Fintan's Hospital, Portlaoise.	Daily		57		804	
Laois 45,069						**314**		2,062
Oflaly 51,533								
St. Columba's Hospital, Sligo.	87,031	(i) Kinlough	Monthly	30 Miles	29		98	
		(ii) Ballinamore	Monthly	40 „	28		109	
		(iii) Cliffoney	Monthly	14 „ .	17		84	
		(iv) Carrick-on-Shannon, Leitrim.	Monthly	35 „	18		86	
Sligo 53,561								
Leitrim 33,470								

*Op«ned 23/3/'65.

District Mental Hospital	Population served	Location of Clinic	Frequency	Approximate distance from Hospital	Number of Patients	Number of Attendances
St. Columba's Hospital, Sligo (contd.).					Grand Total	Grand Total
		(v) Sligo Dispensary	Weekly		41	572
		(vi) Easkey	Twice monthly	26 „	18	119
		(vii) Manorhamilton	Twice monthly	16 „	49	143
		(viii) Mohill	Twice monthly	45 „	46	138
		(ix) Ballymote	Twice monthly	15 „	20	92
		(x) Tubbercurry	Twice monthly	22 „	17	104
		(xi) Sligo County Hospital	When required	—	77	17
		(xii) St. Columba's Hospital	When required		11	1
					291	1,563
St. Ottcran*s Hospital, Waterfordj	71,439	(i) Waterford City and County Infirmary.	Weekly	—	799	2,891
		(ii) Dungarvan	Weekly	29 Miles	464	1,571
		(iii) Ardkeen Hospital	Twice weekly	—	114	667
		(iv) St. Otteran's Hospital, Waterford.	Daily	—	148	409
		(v) Lismore	Weekly	42 „	192	691
		(vi) Rathgormack	Fortnightly	25 „	70	229
		(vii) Kilmacthomas	Fortnightly	16 „	77	305
					1,864	6,763
TOTAL ..	2,818,341				25,395	83,719

APPENDIX H

Private Mental Hospitals and Homes

Name and Location	Proprietors	Admissions 1965	Discharges 1965	Number on Register on 31/12/65	Bed Complement 31/12/65
Belmont Park, Waterford ..	Brothers of Charity	98	91	66	100
Bloomfield, Donnybrook, Dublin.	Society of Friends	14	15	46	51
Carriglea, Dungarvan, Co. Waterford.	Order of Bon Sauveur	24	27	54	65
Hampstead, Glasnevin, Dublin.					
Highfield, Drumcondra, Dublin.	Dr. W. D. Eustace	86	97	59	74
Elmhurst, Glasnevin, Dublin.					
St. John of God Hospital, Stillorgan, Co. Dublin.	Hospitaller Order of St. John of God	600	596	157	180
Kylemore Clinic, Ballybrack, Co. Dublin.	Kylemore Limited	190	183	19	20
Lindville, Blackrock Road, Cork.	Dr. J. D. Sullivan	**353**	350	59	85
Palmerston House, Palmerstown, Co. Dublin.	Committee of Management	*	—	1	8
St. Augustine's, Ratoath, Co. Meath.	Order of St. Augustine of the Mercy of Jesus	25	25	50	50
St. Patrick's Hospital, James's Street, Dublin.	Board of Governors	1,969	1,958	330	358
St. Edmondsbury, Lucan, Co. Dublin.					
St. Vincent's Fairview, Dublin.	Sisters of Charity of St. Vincent de Paul	105	**110**	154	173
Verville, Clontarf, Dublin.	Dr. Mary Sullivan	103	98	48	50
Cluain Mhuire, Newtownpark Avenue, Blackrock, Co. Dublin.	Order of Sisters of Mercy	172	**170**	15	26

•Palmerston House has only 1 patient. It is part of Stewart's Hospital, which caters for the mentally handicapped.

APPENDIX I.

District Mental Hospitals—areas catered for and patient accommodation

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
Ardee	1933	Louth	Louth	Opened in 1933 with 130 male and 104 female patients. Patient population gradually built up to present numbers.	220	150	370	213	143	356
Ballinasloe	1833	City and County of Galway and Counties Sligo, Roscommon, Leitrim and Mayo.	Galway and Roscommon.	Opened in 1833 with 75 male and 75 female patients. In 1871, 180 (Male) beds added and in 1882, 180 (F) beds were added. In 1886, and 1896, 112 (M) and 176 (M) beds were added respectively. Between 1901 and 1905, 182 (M) and 142 (F) beds were added. In 1924, 140 (M) beds were added and in 1938 a further 205 (F) beds were added.	75	75	150	958	617	1,575*
Castlerea (Branch)	1939	Galway and Roscommon (in practice 13 dispensary districts in Roscommon and 2 in Galway).	do.	Opened in 1940 but was transferred to the Tuberculosis service for the period 1948-1955.	216	216	432	202	202	404

*Includes 67 males and 35 females accommodated in Mullingar Mental Hospital.

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
Carlow ..	1832	Carlow, Kildare, Kilkenny and Wexford.	Carlow and Kildare	Opened 1832 with 50 male and 50 female patients. In 1890, a 40-bed extension was added and in 1928 Kelvin House was bought to house 40 male patients. Increased accommodation was provided by reconstructing the original building.	50	50	100	208	182	390
Castlebar	1866	Mayo	Mayo	Opened in 1866 to house 125 male and 125 female patients. In 1904, 345 male and 125 female beds were added. An extension in 1937 increased accommodation to 550 male and 450 female beds. A 52 bed admission block is at present under construction.	125	125	250	552	470	1,022
Clonmel	1834	Tipperary	Tipperary N. and S. Riding	Opened in 1834 with 30 male and 30 female beds. A further 70 beds were added in 1863 and 100 more were added in 1897. Between 1907 and 1910 further extensions were made. In 1933,160 male beds were added and a further 160 beds were made available when adjacent buildings were acquired.	30	30	60	397	301	698

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
*Cork ..	1852	City and County of Cork	Cork County and Cork County Borough	Opened in 1852 to house 250 males and 250 females. In 1896, 2 units designed to give an extra 550 male and 160 female beds were added. In 1941 a 95 bed (male) extension was built and in 1962, 60 female beds were added.	250	250	500	1,005	876	1,881
Youghal (Auxiliary)	1904 (formerly an industrial school)	do.	do.	Opened in 1904 to accommodate 250 male and 200 female patients.	250	200	450	215	139	354
Ennis	1868	Clare	Clare	Opened in 1868 with 130 male and 130 female beds. In 1928,186 male and 14 female beds were added and in 1945, a further 92 male and 92 female beds were provided.	130	130	260	368	257	625
Enniscorthy	1868	Wexford	Wexford	Opened in 1868 with accommodation for 180 male and 150 female patients. By 1945 the hospital accommodated about 520 patients.	180	150	330	235	218	453

*Cork City and County, which provided for their own patients under an Act of 1778, became part of the district asylum system in 1845 when the Cork Lunatic Asylum was declared to be a district asylum. A new and enlarged asylum was opened in 1852.

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
St. Brendan's ..	1814	City and County of Dublin and Counties Meath, Louth, Wicklow and Drogheda town	Dublin County Borough, Dublin County and Wicklow	Opened in 1814 as the Richmond Lunatic Asylum to house 236 patients. It became a district asylum in 1830, and by 1840 it housed 140 males and 150 females In 1850, additions brought the number to 191 male and 235 female. beds. In 1854 a new hospital of 170 beds was added and later an infirmary was built. In the following years additions brought the bed complement to 505 male and 595 female. In 1897 the Richmond Penitentiary was acquired and housed 226 female patients. In 1912 a new 190 bed hospital block was added to the male side, and a 183 bed hospital was also added to the female side. In 1957, a 100 bed (male) unit was built and in 1965, a 75 bed unit was added, for both males and females.	—	—	236	812	918	1,730
Portrane ..	1895	do.	do.	Built to accommodate the overflow from St. Brendan's. Opened in 1895 with 50 patients, but as further buildings were completed they were occupied and by 1900, 400 patients were housed. The hospital population expanded and an isolation hospital was built in 1916. In 1956 two 125 bed units were added, one for males and one for females.	—	—	1,240	884	766	1,650

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
Ballyowen ..	1961 (formerly T.B. Hospital)	City and County of Dublin and County Wicklow	Dublin County Borough, Dublin County and Wicklow	Opened in 1952 as a Tuberculosis Hospital. Transferred to the mental hospital service in 1961. The hospital contains a 30 bed unit for mentally ill children, including psychotic children, autistic children and other emotionally disturbed children.	—	167	167	6	167	173
Kilkenny ..	1852	City and County of Kilkenny	Kilkenny	Opened in 1852 to accommodate 75 males and 75 females. By 1873 the accommodation was 108 male and 108 female and by 1880 it was 149 male and 146 female. In 1895 it was increased to 227 male and 213 female beds. In 1913 it was increased to 275 male and 260 female beds and in 1937, it was further increased to 288 male and 273 female beds.	75	75	150	231	196	427
Killarney ..	1852	Kerry	Kerry	Opened in 1852 to accommodate 130 male and 176 female patients. Between 1875 and 1879 a further 100 male beds were added and in 1891 a further 50 male beds and 100 female beds were added. In 1935, 95 male and 95 female beds were added.	130	176	306	464	366	830

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
Letterkenny ..	1866	Donegal	Donegal	Opened in 1866 to accommodate 150 male and 150 female patients. In 1875, 25 male and 25 female beds were added. By 1886 the accommodation had increased to 235 male and 207 female beds. In 1897, male accommodation was increased to 385 and in 1910 the female accommodation was increased to 280.	150	150	300	357	257	614
Limerick ..	1827	City and County of Limerick and Counties Clare and Kerry	Limerick County and Limerick County Borough	Opened in 1825 to accommodate 75 male and 75 female patients. In 1873 accommodation was increased to 225 male and 200 female beds. In 1934, it was further increased to 420 male and 305 female beds. In 1939 it was again increased to provide for 490 male and 365 female beds.	75	75	150	488	367	855
Monaghan ..	1869	Monaghan and Cavan	Monaghan and Cavan	Opened in 1869 to accommodate 175 male and 175 female patients. In 1886, 60 male and 60 female were added and in 1891 a further 75 male beds were added. In 1901, 40 male and 40 female beds were added and in 1908 a further 120 female beds were provided. In 1960 the admission unit (which had been used for tuberculosis since 1944) became available to cater for 40 male and 40 female patients.	175	175	250	400	349	749

District Mental Hospital	Opened	Area originally catered for	Area now catered for	Extensions and Additions	Original Accommodation			Accommodation 31 December, 1965		
					M	F	Total	M	F	Total
Mullingar	1855	Longford, Meath and Westmeath	Longford, Meath and Westmeath	Built 1850/55 to accommodate 335 male and 228 female patients. In 1890, 62 female beds were added and in 1900, 150 male beds were provided. In 1938, 135 male and 150 female beds were added and an admission unit (50 male and 50 female) was also provided.	335	228	563	541	447	988
Portlaoise	1833	Longford. Westmeath, Laois and Offaly	Laois and Offaly	Opened in 1833 to accommodate 170. In 1895,3 divisions of 76 beds each were added to both the male and female sides. In 1942 a 36 bed male unit and a 40 bed female unit were added.	85	85	170	336	260	596
Sligo	1855	Sligo and Leitrim	Sligo and Leitrim	Opened in 1855 to accommodate 237 male and 233 female patients. In 1936/8, 84 male and 149 female beds were added.	237	233	470	407	303	710
Waterford	1835	City and County of Waterford	Waterford County and Waterford County Borough	Opened in 1835 to accommodate 25 male and 25 female patients. By 1885 there were 160 male and 149 female beds. In 1907 an Infirmary was added to both the male and female sections and the hospital can now accommodate 293 male and 211 female patients.	25	25	50	293	211	504
Newcastle	1966	County Wicklow	County Wicklow							
										17,584

APPENDIX J

Staff in Private Mental Hospitals and Homes

Institution	Physician-in-charge	Psychiatrists (Full-time)	Psychiatrists (Part-time)	Psychologists (Full-time)	Psychologists (Part-time)	Other Medical Consultants on call	Visiting General Practitioners	Psychiatric Nurses (Male)	Psychiatric Nurses (Female)	General Trained Nurses	Psychiatric Social Workers	Occupational Therapists	Tutors	Student Nurses
Belmont Park, Waterford	—	1	—	—	—	6	3	4	—	2	—	1	1	12
Bloomfield, Donnybrook, Dublin	1	—	1	—	—	1	—	—	2	2	—	1	—	—
Carriglea, Dungarvan, County Waterford	1	—	1	—	—	1	—	—	5	2	—	1	—	—
Hampstead, Highfield and Elmhurst, Glasnevin, Dublin	—	2	—	—	—	2	*—	—	2	6	—	1 (P.T.)	—	—
St. John of God Hospital, Stillorgan, County Dublin	—	5	—	—	—	**	—	40	7	1	—	1	—	—
Kylemore Clinic, Ballybrack, County Dublin	—	2	1	—	—	**	4	—	1	7	—	1 (P.T.)	—	—
Lindville, Blackrock Road, Cork	—	2	—	—	1	8	1	4	9	9	—	1	—	—
†Palmerston House, Palmerstown, County Dublin	—	1	—	—	1	**	2	6	3	10	—	1	—	—
St. Augustine's, Ratoath, County Meath	—	—	1	—	—	**	1	—	5	2	—	—	—	—
St. Patrick's Hospital, James's Street, Dublin St. Edmondsbury, Lucan, County Dublin	—	11	2	—	1	2	—	10	31‡	2	1	5	—	44
St. Vincent's, Fairview, Dublin	1	—	1	—	—	1	—	—	16	3	—	—	—	26
Verville Retreat, Clontarf, Dublin	1	—	—	—	—	**—	—	—	4	6	—	1	—	—
Cluain Mhuire, Newtownpark Avenue, Blackrock, County Dublin	—	—	10	—	—	4	3	—	—	5	—	1	—	—

•Medical Practitioners visit their own patients. **In accordance with patients' needs. fPalmerston House has only 1 patient. It is part of Stewart's Hospital, which caters for mentally handicapped. {Includes 14 nurses, qualified in both psychiatric and general nursing.

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